



‘SANISM’, A SOCIALLY ACCEPTABLE PREJUDICE:
ADDRESSING THE PREJUDICE ASSOCIATED WITH
MENTAL ILLNESS IN THE LEGAL SYSTEM

BY

VALERIE WILLIAMS

SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR
THE DEGREE OF DOCTOR OF PHILOSOPHY

UNIVERSITY OF TASMANIA

FACULTY OF LAW

NOVEMBER, 2013

STATEMENTS

This thesis contains no material which has been accepted for a degree or diploma by the University or any other institution, except by way of background information and duly acknowledged in the thesis, and to the best of the candidate's knowledge and belief, no material previously published or written by another person except where due acknowledgment is made in the text of the thesis,

The research associated with this thesis abides by the international and Australian codes on human and animal experimentation, the guidelines by the Australian Government's Office of the Gene Technology Regulator and the rulings of the Safety, Ethics and Institutional Biosafety Committees of the University.

Signature

Date

This thesis may be made available for loan and limited copying in accordance with the *Copyright Act 1968* (Cth).

ACKNOWLEDGEMENTS

First, I wish to acknowledge my supervisors, Associate Professor Rick Snell and Dr Jeremy Pritchard, who gave me freely of their time, advice, encouragement and guidance. To them, I offer my sincerest gratitude for their support, which has spanned the euphoric highs and the debilitating lows that have been my life during the past four years. Thank you. I also acknowledge and thank Daniel de la Motte for his work in designing a data capturing system, which was both easy to understand, but more importantly, easy to use. I also want to acknowledge and thank Dr Jason Little for his invaluable statistical assistance in helping to me to accurately interpret the captured data and to validate the results set out in Chapter Eight. My gratitude also flows to Dr Elise Histed for her friendship and support. My thanks are also given to the teaching and administrative staff of the University of Tasmania School of Law. They have been my teachers, colleagues, mentors, supporters and friends, many for more than 20 years. My gratitude is also given to Katie Purchas and Charlotte Hunn for their administrative support. Finally, I wish to thank the hundreds of University of Tasmania law students who participated in the study. The information gained from their responses will prove a valuable resource in developing and implementing future policies and programs, which will positively influence the impact that the legal system has on people who experience mental illness.

Table of Contents

INTRODUCTION.....	1
CHAPTER ONE MENTAL HEALTH: AN AREA OF CONCEPTUAL AND DEFINITIONAL CONFUSION	26
CHAPTER TWO MENTAL ILLNESS: SOCIAL, MEDICAL AND LEGAL LABELLING	69
CHAPTER THREE CONCEPTUALISING STIGMA: STEREOTYPES, PREJUDICE AND DISCRIMINATION.....	99
CHAPTER FOUR CHALLENGING STIGMA: THE INTERMIX OF POLICY, LAW AND CULTURAL INTERVENTION	151
CHAPTER FIVE THE CONTROVERSIAL CONCEPTS OF SANISM AND PRETEXTUALITY	221
CHAPTER SIX THE LEGAL SYSTEM’S ‘SANIST TREATMENT’ OF PARENTS WHO EXPERIENCE MENTAL ILLNESS	266
CHAPTER SEVEN THE MENTAL HEALTH TRIBUNAL REPRESENTATION SCHEME.....	319
CHAPTER EIGHT EMPIRICAL FINDINGS OF LAW STUDENT ATTITUDES TO PEOPLE WHO EXPERIENCE MENTAL ILLNESS	369
CONCLUSION	442
APPENDIX 1	455
APPENDIX 2	456
APPENDIX 3	457
APPENDIX 4	459
APPENDIX 5	463
APPENDIX 6	466

LIST OF TABLES

Table 1 – Demographics of study participants.....	387
Table 2 – Participant numbers and percentages.....	388
Table 3 – Percentage of ‘No opinion’ responses to all Items by 1 st year and Final year students	390
Table 4 – Percentage of ‘Agreement’ and ‘Disagreement’ responses by 1 st year and Final year students by gender (total females = 158, total males = 98)	392
Table 5 – Percentage of ‘Agreement’ and ‘Disagreement’ responses by 1 st year and Final year students by gender (total females = 158, total males = 98)	395
Table 6 - Recognizing a person as ‘having a mental illness’	399
Table 7 – Group 1 - agreement and disagreement by year (total 1 st years = 193, total final years = 63).....	403
Table 8 – Group 1 - agreement and disagreement by year (total 1 st years = 193, total final years = 63).....	404
Table 9 – Group 2 - Agreement and disagreement by personal experience of mental illness reporting	406
Table 10 – Group 2 - Agreement and disagreement by personal experience of mental illness reporting	408
Table 11 – Group 2 - Agreement and disagreement by MHTRS participation	411
Table 12 – Group 2 - agreement and disagreement by MHTRS participation	413

LIST OF FIGURES

Figure 1a – MI legal clients would be difficult to represent	388
Figure 1b – MI are stigmatised and discriminated against	389
Figure 2 – Final Page Q3 – ‘Do you use terms such as loony...’ – MI/no MI Groups	409
Figure 3 –MI should be treated differently to other people (II1 –Table 11).....	412
Figure 4 – MI legal clients should be treated differently (IJ12 Table 12)	412
Figure 5 – Final Page Q3 – ‘Do you use terms such as loony...’ MHTRS/no MHTRS	414

INTRODUCTION

1. ABSTRACT

The thesis explores society's prejudice and intolerance toward mental illness. It provides a narrative reference to stigma, which is drawn primarily from the biosocial science disciplines, and applies it to the law and its implementation. It examines the limited success that health policies, legislation, cultural interventions and anti-stigma campaigns have had in reducing stigma to which the better achievements appear to have resulted from short term, specialist education and contact programs targeting young people. It investigates the impact that labelling and harmful stereotypes, which inform biased decision-making have on the opportunities for people experiencing mental illness to receive fair and equitable legal outcomes. In this regard, the thesis explores Michael Perlin's controversial notion of sanism: an irrational but socially acceptable prejudice directed against people with mental illness. Perlin argues that the legal system is so embedded with stigmatising myths and negative stereotypes that its discriminatory actions largely go unnoticed, or unacknowledged, or are justified as legal actions and behaviours that are acceptable in the circumstances; those circumstances being that the person has a mental illness.

Perlin's ideas have developed primarily from thirty years of personal observation, which to date have not been critically tested. This thesis set about examining Perlin's sanism propositions through a combination of doctrinal and empirical research. The doctrinal analysis centred upon conflicted parenting decisions, which identified the presence of sanism in legal decision-making and legislation.

Secondly, a review of 296 Australian family law conflicted parenting order cases decided between 2006 and 2011 was conducted. The findings indicated that parents who have an experience of a mental illness, or merely appear to the court to have a mental illness, are at significant risk of having their parental responsibilities severely restricted, or removed entirely, on the basis of their stereotypification as an

unfit parent and their categorisation as an ‘unacceptable risk’ to the wellbeing and safety of their child.

The empirical assessment of Perlin’s views regarding sanist law students is the first of its kind. A survey study was conducted that examined attitudes about people experiencing mental illnesses generally, and legal clients particularly of (N=204) students entering law school and (N=81) students exiting law school. Overall, the results supported Perlin’s perspectives. They indicated that the student’s attitudes were, to a high degree, authoritarian and benevolently prejudicial. There were few significant differences based on variables of gender and self identification of a mental illness although the data revealed a large, culturally significant difference between domestic and overseas respondents and female respondents were significantly more benevolent in their attitudes than the males. The final component of the research involved an evaluation of the Tasmanian Mental Health Tribunal Representation Scheme (MHTRS) which has operated since 2003. It uses a therapeutic jurisprudence model to train volunteer law students to represent people appearing before the Tasmanian Mental Health Tribunal. It was anticipated that participating in the MHTRS would reduce sanist attitudes among students; however, this study did not establish a consistently positive change in the attitudes of the participant respondents. Overall, the thesis provides valuable insight into the planning of future strategies designed to reduce the prejudice and discriminations that people with a mental illness experience when confronting the legal system.

2. PURPOSE OF THE THESIS

The first purpose of this thesis is to examine Perlin’s claims that the legal system is embedded with the hidden prejudice associated with mental illness: sanism.

Exposing sanism in this way will contribute to both a reduction in the discriminatory treatment of service users experiencing a mental illness and an improvement in the opportunities available for this disadvantaged group to achieve fair and just legal outcomes. Other than Perlin’s numerous articles and the small number of others authored by supporters of his concepts of ‘sanism’ and ‘pretextuality’, the majority of legal commentators have, as yet, failed to recognise or address the socially acceptable prejudices perpetrated by the legal system’s

mentally powerful against the mentally vulnerable. Sanism, it seems, offers the last bastion of acceptable prejudice.

To understand why and how these prejudices continue to pervade policies, laws and legal and social practices, it is necessary to examine contextually the concepts of mental health and mental illness within their medical, social and legal parameters. It is also important to preface the discussion with a sociological exploration of the concept of stigma so as to understand how negative attitudes and beliefs create social distance; erect institutional barriers between the ‘powerful’ and the ‘powerless’; and justify as acceptable, outcomes which would be unacceptable if the party did not have a mental illness. Once stigma and sanism are exposed in this way, and the unacceptable is no longer acceptable, it will be necessary to develop and implement policy and program change initiatives to effect positive cultural and systemic change.

The second purpose of this thesis is to promote as a future change initiative, the establishment of mental health clinical legal education programs similar to the therapeutic jurisprudence model presented in Chapter Seven. An evaluation of the Mental Health Tribunal Representation Scheme was undertaken. Data was collected from a questionnaire completed by 285 University of Tasmania law students responding to questions about mental illness generally, and legal clients experiencing mental illness specifically. Although the research did not achieve a significantly clear measure of the positive impact that the program had on students, it did provide valuable insight into the need for further research on the topic as well as constructive information on how survey procedures can be improved.

3. JUSTIFICATION OF THE THESIS

The PhD is awarded on the basis of a thesis prepared under supervision that makes an original, significant and extensive contribution to knowledge and understanding in the relevant field of study. To this end, the thesis undertakes a narrative analysis of the social phenomenon of stigma and sanism through the examination of an extensive number of medical, legal and social science academic publications. It also examines policies, laws and practices utilised by political and social institutions

with the intention of reducing the stigma, and decreasing the discrimination associated with mental illness in the legal system.

Stigma infects the lives of people experiencing mental illness by diminishing their self-esteem and robbing them of social opportunities. Although it is widely accepted that stigma gives cause to prejudice, social rejection, isolation and discrimination, this is not so when it comes to the law. The perception of neutrality, impartiality, fairness and justice tend to override thoughts that prejudice and discrimination associated with mental illness might be both inherent and embedded in the law's doctrines, statutes and practices as Michael Perlin contends. It is a very thorny road to acceptance that the legal system's biased and pretextual treatment of parties experiencing mental illness can deny, or significantly limit basic rights and freedoms.

Support for Perlin's sanist theory is increasing, although it seems, mostly amongst mental health professionals and consumers. Other than Perlin's own extensive writings, there has been very little academic discussion on the topic, and virtually no empirical research undertaken to support or dispute Perlin's claims. This thesis fills the void by offering (1) academic discourse on the social acceptability of mental health prejudice, (2) original research of recent Australian family law parenting order cases in an attempt to identify a sanist judicial approach to decision-making when a parent is believed to have a mental illness, and (3) a large, original quantitative and qualitative research study that examines the attitudes of law students to mental illness generally, and to legal clients with a mental illness specifically. It compares the attitudes of respondents who had participated in a mental health therapeutic jurisprudence clinical legal education program with non-participants to determine whether participation improves attitudes.

The thesis provides evidence that helps make Perlin's concept of sanism more visible, and less socially acceptable, and it offers recommendations for initiating positive change mechanisms among law students. It has the overall aim of decreasing the prejudice and disadvantage that a very vulnerable group of individuals presently face when they confront the legal system.

4. LANGUAGE OF THE THESIS

Words are important. If you want to care for something, you call it a ‘flower;’
if you want to kill something, you call it a ‘weed.’¹

People who experience a mental illness are commonly represented as being essentially different from the rest of society. They are detrimentally defined by their illness and consequently, distanced and excluded. Stereotypical misconceptions and fears provide fertile ground for the propagation of stigma, prejudice and discrimination. The use of dated and inaccurate descriptors can enable the perpetuation of negative stereotypes, and reinforce the incredibly powerful and potent attitudinal barriers that are encountered daily by people who have a mental illness. Using the right kind of language can promote awareness of mental illness and provide a better understanding of the needs and concerns of people who experience mental illness and their associated mental health problems.

Language itself is a totality of determined notions and concepts, and not just words grammatically devoid of content.²

The object of language is to describe the user’s view of mental illness, and people who have a mental illness, and while terms such as ‘nut case’ and ‘psycho’ help to form language, they can also impose limits of empathy on speakers. This thesis supports the proposition that the language used does matter. It accepts that the use of ‘people first language’³ is an objective way of acknowledging, respecting, communicating and reporting on mental health issues in a way that helps to eliminate generalisations, assumptions and stereotypes by focusing on the person rather than their illness. As their illness does not define who the person is but simply identifies something that they experience, the thesis will follow a linguistic framework that consistently uses the more cumbersome term ‘people who experience mental illness’ as a broad reference to individuals who have either a diagnosed or undiagnosed, treated or untreated mental disorder or mental illness/or

¹ Don Coyhis, member of the Mohican Nation from the Stockbridge-Munsee Reservation in Wisconsin in William White, ‘The Rhetoric of Recovery Advocacy: An Essay on the Power of Language’ (Research Paper, 2001) <<http://naabt.org/documents/LANGUAGEBillWhite.pdf>>.

² Antonio Gramsci, *Selections from the Prison Notebooks of Antonio Gramsci* (Quentin Hoare and Geoffrey Nowell Smith editors and translators), (Smith International Publishers, 1971) 323.

³ Kathie Snow, ‘People First Language’ (2008) <http://www.acdd.org/wp-content/uploads/2011/01/People_First_Language.pdf>. Written in 1991 but updated regularly, it is accepted as the definitive disability language use manual.

are experiencing mental health problems or psychiatric disabilities rather than use the widely accepted, simpler and more euphonious term, ‘the mentally ill’.

Establishing the consistency of the language to be used throughout the thesis was a difficult exercise due largely to the historical and comparative aspects of a subject that spans medical, legal, sociological, theoretical and empirical perspectives over many eras. It is important, therefore, to acknowledge the unavoidable level of language changeability that will become evident reading the thesis. Commentators and researchers use descriptive terms common to their discipline with early commentators and researchers referring to the ‘insane’ or ‘the lunatic’ while recent social commentators focus on the ‘vulnerable’ and ‘disadvantaged’. Health professionals tend to refer to them as patients or sufferers while services and practitioner specific focused bureaucrats, administrators and service delivery personnel identify them as ‘consumers’, ‘service users’, ‘users’, ‘stakeholders’, ‘participants’ or ‘clients’. The people who experience mental illness may themselves identify as a patient, consumer, psychiatric survivor or even a victim. They may embrace ‘mad pride’ and reclaimed ‘mad speak’ and choose to refer to them self as ‘mad’ or ‘a crazy person’.

In the United States, ‘mentally retarded’ or ‘mentally challenged’ are acceptable while in the United Kingdom and Australia, ‘mentally retarded’ is offensive. Instead, the terms ‘mentally ill’, ‘mentally disordered’ or ‘psychiatrically disabled’ are prominent in use. Although many commentators now prefer the term ‘mental disorder’ rather than ‘mental illness’, the term ‘mental illness’ is used throughout this paper as an overarching descriptor for the collective of mental disorders.

According to the Australian government, ‘mental illness’ is defined as a general term that refers to a group of illnesses, in the same way that ‘heart disease’ refers to a group of illnesses and disorders affecting the heart.⁴ Mental illness is also widely accepted in common language usage as the appropriate descriptor for the cause behind the manifestation of unacceptable behaviour. The use of the term ‘mental illness’ also supports the goal of the empirical research undertaken which was to identify encompassing, general attitudes towards people experiencing mental illness

⁴ ‘What is Mental Illness’, Mental Health and Workforce Division of the Australian Government Department of Health and Ageing,
<http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0003/38442/what_is_mental_illness.pdf>

rather than garnering respondents' attitudes to particular subgroups of people with specific diagnoses such as schizophrenia, depression or anxiety.

'Health' is conceived from the medical and legal perspectives as a biomedical construct and from the sociological perspective as a functioning and well-being construct and its discussion and analysis within the thesis flows across all three perspectives. The term 'mental health' is used most frequently because it is consistent with common language and encapsulates the topic areas discussed in the thesis such as 'mental health care and treatment' by 'mental health professionals', 'mental health problems' and 'mental health law'. It is also used positively in reference to the preventative promotional aspects of public health policies.

It is not the intention of this thesis to homogenise the spectrum of language used in the literature that underlies much of the content of the thesis, and so, to a large extent, the text tries to keep in step with the language common to the discussion occurring in a particular section i.e. discussions relevant to hospitalisation may refer to people with a mental illness as patients although generally throughout the thesis, the term will be avoided because of its strong medical inferences. Finally, it is important to highlight the fact that particular terms always carry different connotations for different people as mental health language continues to be used interchangeably, and perspective specifically, despite the best intentions of this, or any other, paper.

5. RATIONALE FOR METHOD OF INQUIRY

The rationale for the student survey was to test two research questions: (1) do law students have prejudicial attitudes toward mental illness that change during their period of legal education, and (2) does positive attitudinal change occur if the student participates in a program similar to the Mental Health Tribunal Representation Scheme (MHTRS)? The inquiry utilised both quantitative and qualitative research methods, the first of which drew data from the responses to a questionnaire consisting of approximately 80 questions intended to identify student attitudes toward mental illness, mental health laws, and the legal representation of people with a mental illness. Before commencing the survey roll-out, ethics approval was provided by the University of Tasmania Ethics Committee. Surveys

did not collect any identifying particulars, and in those cases where participants did provide identifying details, this information was removed and only de-identified particulars were reported. The survey was then completed by 204 first year law students who were in the first 6 weeks of commencement their legal studies and by 81 final year law students during the last 6 weeks of their legal education. The analysis of the responses was influenced by the developmental continuum from first year education to final year education.

6. METHOD FOR SEARCHING AND SELECTING MATERIAL

The literature reviewed for the thesis included Australian and international academic journals as well as a significant amount of grey literature consisting of unpublished and non-commercially published government reports, policy statements and issues papers, conference proceedings, pre-prints and post-prints of articles, theses and dissertations, research reports, letters, newsletters and bulletins and fact sheets. The grey literature was largely sourced from the mental health websites of government and non-government organisations.

Three approaches were taken in searching the literature. The general literature approach searched the PubMed, PsychINFO, Scopus and Google Scholar databases as well as other health and social science related sources using the University of Tasmania University Library services for journal articles and population studies on mental illness, mental health stigma, attitudinal change and mental illness stigma reduction directions and interventions. Search keywords were used individually and in combinations, and included ‘mental illness’, ‘mentally ill’, ‘mental health’, ‘deinstitutionalisation’, ‘stigma’, ‘stigma reduction’, ‘intervention’, ‘antistigma’, ‘education’, ‘attitudinal change’, ‘social distance’, ‘contact’ and ‘political correctness’. On completion of the electronic search, manual searches of the citations listed in identified articles and studies were undertaken. In addition, the bibliographies of relevant references were searched to identify related references not found in the electronic database search.

The second approach undertook a search of the legal literature. LexisNexis, Austlii, NZlii, LII, Ballii, WorldII and Google Scholar were interrogated for relevant legal

journal articles, cases and legislation. Search keywords were again used individually and in combinations and included ‘mental illness’, ‘psychiatric report’, ‘mentally ill parent’, ‘neglect’, ‘abuse’, ‘sanism’, ‘judicial bias’ and ‘decision-making’. Pejorative search terms such as ‘lunatic’ and ‘psycho’ were also used. As was the case with the general literature search, the bibliographies of some of the literature revealed further relevant references that were not found in the electronic database search.

The third approach primarily relied on Google, an online search engine database to search for relevant grey literature. A large number of websites were identified that were found to hold relevant resources. These included government websites such as the Australian Government Department of Health and Ageing, various Australian state and territory government health directorates, the U.S. Department of Health and Human Services and the U.K. Department of Health. Countless non-government sites were also accessed which included the World Health Organization, Mental Health Council of Australia, Sane, Mind Australia and Mind United Kingdom, Schizophrenia Society websites, mental health consumer websites and psychiatric colleges. The bibliographies of relevant references were searched to identify related references and a manual search of library catalogues was undertaken to further identify relevant resources. Past policies that were not available electronically were obtained through personal request from the relevant body, or through Document Delivery when no longer held in hard copy print form.

Google was also used to search for global media reports related to mental illness. Newspaper and television articles provided an important contribution to the thesis as they presented an, often immediate, measure of the public’s mood toward many of the key factors that fuel mental illness stigma such as community integration, treatment non-compliance and the limited availability of community support services, violence and sentencing.

7. LITERATURE REVIEW

The stigma associated with mental illness is pervasive and widespread.^{5 6} Society has had a long and ubiquitous history of negative response to the changing notions of mental illness ranging from the primitive belief in divine or demonic affliction to the scientific rise of medical theories and psychotherapeutic models of moral blameworthiness to the current, biologically based explanations of mental disorders.⁷ Society's marginalised members have always experienced discrimination as a result of the stigmatiser's belief in erroneous myths and negative stereotypes that lead to prejudiced attitudes which, in turn, lead to discriminatory actions.⁸ But throughout history, it has been people who experience mental illness that have induced the most negative of all of public attitudes and social discriminations.⁹

Stigma has been conceptualised by a number of diverse disciplines and has been attributed various meanings and definitions, none of which are definitive, and all of which are subject to academic debate.¹⁰ Contemporary understanding of stigma is grounded in the sociological and psychological theoretical traditions that stem largely from Erving Goffman's classic revisionist concept laid down in his seminal book, *Stigma: notes on the management of spoiled identity*.¹¹ Based primarily on dyadic social interaction, the central feature of Goffman's view of social stigma is that individuals who possess attributes or characteristics that fall short of social expectations are devalued and dehumanised, irredeemably tainted and discounted¹² and disqualified from full social acceptance.¹³

⁵ Liz Sayce, 'Stigma, discrimination and social exclusion: What's in a word?' (1998) 7 *Journal of Mental Health* 331.

⁶ Arthur H Crisp *et al.*, 'Stigmatisation of people with mental illness' (2000) 177 *British Journal of Psychiatry* 4.

⁷ Heather Stuart, 'Fighting the stigma caused by mental disorders: past perspectives, present activities, and future directions' (2008) 7 *World Psychiatry* 185.

⁸ Matthew Schumacher, Patrick W Corrigan and Timothy Dejong, 'Examining cues that signal mental illness stigma' (2003) 22 *Journal of Social and Clinical Psychology* 467.

⁹ Phyllis A Gordon *et al.*, 'Attitudes regarding interpersonal relationships with persons with mental illness and mental retardation' (2004) 70 *Journal of Rehabilitation* 50.

¹⁰ Bruce G Link *et al.*, 'Measuring Mental Illness Stigma' (2004) 30 *Schizophrenia Bulletin* 511.

¹¹ Erving Goffman, *Stigma: notes on the management of spoiled identity* (Prentice-Hall, 1963). Goffman's book can be credited with conceptualizing stigma and creating a framework for the wealth of academic study during the past 47 years.

¹² *Ibid* 3.

¹³ *Ibid* 9.

Goffman viewed mental illness as one of the most deeply discrediting and socially damaging of all stigmas.¹⁴ He, as were many of his contemporaries such as Szasz¹⁵ and Scheff¹⁶, was highly critical of the role that mental hospitals played in reinforcing the stigma associated with diagnostic labelling and psychiatric treatment.¹⁷ Some commentators continue to hold the view that psychiatrists contribute to stigma through the careless use of diagnostic labels and inappropriate treatments.¹⁸ Generally, social theorists have moved away from the early focus on stigma as a derivative of the social organisation of psychiatry. Stigma's creation and continuance is now considered the result of a much more complex interplay of social-structural, interpersonal and psychological factors.¹⁹

Corrigan deconstructed public stigma into three elements: stereotypes, prejudice and discrimination.²⁰ Thornicroft later revised Corrigan's definition by including problems of (1) knowledge (ignorance or misinformation), (2) attitudes (prejudice), and (3) behaviour (discrimination).²¹ Discrimination exists in society's norms, values and institutions and is separated into three types (1) individual (2) institutional and (3) structural.²² Corrigan's theory of structural discrimination²³ is widely believed to be the most egregious form of indirect discrimination because of the pervasive impact that society's basic institutions have on people's lives.²⁴ Pervasive, pernicious, and resistant to change,²⁵ stigma is embedded within society's institutions especially, according to Perlin, its legal system.²⁶

¹⁴ Stephan P Spitzer and Norman K Denzin (eds) *The mental patient* (McGraw-Hill, 1968) Erving Goffman, The moral career of the mental patient, 226.

¹⁵ Thomas Szasz, 'The myth of mental illness' (1960) 15 *American Psychologist* 113.

¹⁶ Thomas J Scheff, *Being mentally ill: a sociological theory* (Weidenfeld & Nicolson, 1967).

¹⁷ Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Doubleday & Co. Anchor Books, 1961).

¹⁸ Norman Sartorius, 'Iatrogenic stigma of mental illness' (2002) 324 *British Medical Journal* 1470.

¹⁹ Jo C Phelan and Bruce Link, 'Conceptualizing Stigma' (2001) 27 *Annual Review of Sociology* 363.

²⁰ Patrick W Corrigan, *On the Stigma of Mental Illness* Washington (American Psychological Association, 2005). See also Patrick W Corrigan and Amy C Watson, *The paradox of self-stigma and mental illness* (Clinical Psychology: Science and Practice, 2002) 35.

²¹ Graham Thornicroft *et al.*, 'Stigma: ignorance, prejudice or discrimination?' (2007) *British Journal of Psychiatry* 190, 193.

²² Patrick W Corrigan, Fred E Markowitz and Amy C Watson, 'Structural Levels of Mental Illness: Stigma and Discrimination' (2004) 30 *Schizophrenia Bulletin* 481.

²³ Patrick W Corrigan and Amy C Watson, 'Understanding the impact of stigma on people with mental illness' (2002) 1 *World Psychiatry* 16.

²⁴ John Rawls, *A Theory of Justice* (Harvard University Press, 1971).

²⁵ Heather Stuart, Julio Arboleda-Florez and Norman Sartorius, *Paradigms Lost: Fighting Stigma and the Lessons Learned* (Oxford University Press, 2012).

²⁶ Michael Perlin, *The Hidden Prejudice: Mental Disability on Trial* (American Psychological Association, 2000).

In his book, *The Hidden Prejudice of Law: Mental Disability on Trial*²⁷, Michael Perlin provides a comprehensive critique of mental health law in the United States. He argues that legal decision-making, when mental illness is a factor, is tainted by bias and an irrational prejudice of the same quality and character as other irrational prejudices that cause, and are reflected in, prevailing social attitudes.²⁸ He labels the irrational prejudice associated with mental illness, rooted in stereotypes, myths, superstition, and deindividualisation, ‘sanism’. Contentiously, he claims that sanism pervades the legal system, where it is mostly invisible, and largely socially acceptable. And, in combination with pretextuality, the legal system’s pattern of discriminatory and dishonest artifices, they distort both the legislative and judicial processes to prevent people experiencing a mental illness from receiving equal treatment under the law.²⁹ Perlin’s claims are not unsupported, however. Porter, for example, suggests that judges are susceptible to critical thinking errors because they adopt myths and false stereotypes which they rely on to justify their biased view of the facts, using them to support their initial, unreliable assessments, particularly regarding dangerousness and trustworthiness.³⁰

Perlin defines sanism as attitudinal disease³¹ and irrational prejudice.³² Large distinguishes prejudice and stigma. For him, stigma is about society’s intolerance, lack of acceptance, and lack of compassion for people who are different³³ while prejudice is about pre-judged negative feelings and opinions that a person forms out of ignorance, or without thought or reason.³⁴ Phelan suggests that the conceptual models of stigma and prejudice have much in common.³⁵ Thornicroft views stigma as the overarching term for stereotypical ignorance, prejudice and discrimination³⁶

²⁷ Ibid.

²⁸ Michael L Perlin, ‘“Things Have Changed:” Looking At Non-Institutional Mental Disability Law Through The Sanism Filter’ (2003) 46 *New York Law School Law Review* 535.

²⁹ Michael L Perlin, ‘Simplify You, Classify You: Stigma, Stereotypes and Civil Rights in Disability Classification Systems’ (2008/09) 25 *Georgia State University Law Review* 607.

³⁰ Stephen Porter, Leanne ten Brinke and Chantal Gustaw, ‘Dangerous decisions: the impact of first impressions of trustworthiness on the evaluation of legal evidence and defendant culpability’ (2010) 16 *Psychology, Crime & Law* 477, 478. See also Norbert L Kerr, Robert J MacCoun and Geoffrey P Kramer, ‘Bias in Judgment: Comparing Individuals and Groups’ (1996) 103 *Psychological Review* 687.

³¹ Michael L Perlin, *‘They’re An Illusion to Me Now’: Forensic Ethics, Sanism and Pretextuality* (Research Paper No 07/08 # 27, New York Law School Legal Studies, 2008) <<http://ssrn.com/abstract=1130923>>.

³² Michael L Perlin, ‘His Brain Has Been Mismanaged with Great Skill’: How Will Jurors Respond to Neuroimaging Testimony in Insanity Defense Cases?’ (2009) 42 *Akron Law Review* 885.

³³ Matthew Large and Christopher J Ryan, ‘Sanism, stigma and the belief in dangerousness’ (2012) 46 *Australian & New Zealand Journal of Psychiatry* 1099.

³⁴ *Macquarie Dictionary* (Macquarie University Press, 5th ed, 2009).

³⁵ Jo C Phelan, Bruce G Link and John F Dovidio, ‘Stigma and prejudice: one animal or two?’ (2008) 67 *Social Science and Medicine* 358.

³⁶ Thornicroft, above n 21.

while Poole presents stigma as an overarching oppression constructed on a foundation of sanist beliefs, attitudes and practices.³⁷ Parry argues that prejudicial beliefs and discriminatory behaviours are elements of both stigma and sanism because ‘sanism produces stigma and stigma leads to sanism’.³⁸ Although sanism features an ideological rationalisation or justification for stigmatising and marginalising the ‘Other’, the dominant principle shared by all ‘isms’, it is also set apart from them. Sanism brings with it additional and unique elements. Sanism is largely invisible, socially acceptable, and frequently practised.³⁹

There has been a substantial amount of social science research conducted over past decades that has examined the concepts of stigma, prejudice and discrimination, identified key indicators in the promotion of positive social change, and recommended strategies designed to reduce stigma and decrease discrimination. Corrigan’s study examining the effect of the anti-stigma strategies of education, contact and protest found that education and contact were effective while protest was not.⁴⁰ Angermeyer suggested increasing the public’s knowledge of mental illness through communication strategies, offering more community supports for people experiencing mental illness and their families; changing mental health care by improving the quality of care services provided to consumers; and providing education and training including to lawyers and judges.⁴¹ A later study of Corrigan’s found that while education yielded positive results, contact with a person experiencing a mental illness produced stronger results.⁴² Alexander and Link concluded that as any type of contact with a person experiencing a mental illness increased, the perception of the person as physically dangerous decreased, as did the desire for social distance from them.⁴³ Reinke and Corrigan found that a significant

³⁷ Jennifer M Poole *et al.*, ‘Sanism, ‘Mental Health’, and Social Work/Education: A Review and Call to Action’ (2012) 1 *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice* 20.

³⁸ John D Parry, *Criminal Mental Health and Disability Law, Evidence and Testimony: A Comprehensive Reference Manual for Lawyers, Judges and Criminal Justice Professionals* (American Bar Association, 2009) 48.

³⁹ Richard Ingram, ‘Sanism in Theory and Practice’ (Workshop, 2nd Annual Critical Inquiries, 9-10 May 2011) <http://www.socialinequities.ca/wordpress/wp-content/uploads/2011/07/Ingram.Sanism-in-Theory-and-Practice.CI_2011.pdf>.

⁴⁰ Patrick W Corrigan and David L Penn, ‘Lessons from social psychology on discrediting psychiatric stigma’ (1999) 54 *American Psychologist* 765.

⁴¹ Matthias C Angermeyer, Beate Schulze and Sandra Dietrich, ‘Courtesy stigma: A focus group study of relatives of schizophrenia patients’ (2003) 38 *Social Psychiatry and Psychiatric Epidemiology* 593.

⁴² Patrick W Corrigan *et al.*, ‘Challenging two mental illness stigmas: Personal responsibility and dangerousness’ (2002) *Schizophrenia Bulletin* 293.

⁴³ Laurel A Alexander and Bruce G Link, ‘The impact of contact on stigmatizing attitudes towards people with mental illness’ (2003) 12 *Journal of Mental Health* 271.

period of discourse contact needs to occur between the public and the person with a mental illness for contact to be an effective strategy.⁴⁴

One of the major findings of a recent comprehensive review of public stigma research undertaken by Angermeyer found that there was strong evidence that negative attitudes are positively associated with age.⁴⁵ In the nineteen fifties, Whately concluded that the variance that he found associated with age was likely a form of culturally generated liberalism.⁴⁶ He interpreted the positive responses amongst younger people as a probable reflection of the liberal attitudes of contemporary society: a manifestation of the cultural changes occurring. He found it untenable that the negative responses of older people were the yield of a psychological conservatism produced by growing old, preferring instead the hypothesis that the unfavourable responses reflected the learned attitudes of a less enlightened bygone past. Whately's argument was that age shared a large part of its common factor variance with education, income and occupation which, he concluded, usually correlated with liberal, humanitarian attitudes.⁴⁷

Angermeyer did not find that a consistent relationship existed between the socio-demographic characteristics of age, education or familiarity of the respondents and the beliefs they held about people who experienced mental illness. Although 32 studies had indicated that negative attitudes were positively associated with age, 10 had concluded that age did not matter. Only one study found that the reverse relationship existed. That study had examined attitudes towards the compulsory admission of people experiencing a mental illness and reported that the older the person (aged 56 -76) did not accept the psychiatric hospital as an appropriate setting and were opposed to compulsory admission.⁴⁸ One explanation for the negative response may be that older people apply a more learned approach to forming their attitudinal responses. Rather than weighting responses in the existence of age specific cultural differences, the older person's personal sense of proximity to the

⁴⁴ Rebecca Reinke *et al.*, 'Examining Two Aspects of Contact on the Stigma of Mental Illness' (2004) 23 *Journal Of Social And Clinical Psychology* 377.

⁴⁵ Matthias Angermeyer and S Deitrich, "Public beliefs about and attitudes towards people with mental illness: a review of population studies' (2006) 113 *Acta Psychiatrica Scandinavica* 163, 174.

⁴⁶ Charles D Whatley, 'Social Attitudes Toward Discharged Mental Patients' (1959) 6 *Social Problems* 13, 316 – 317.

⁴⁷ *Ibid.*

⁴⁸ Christoph Lauber *et al.*, 'Public Attitude to compulsory admission of mentally ill people' (2002) 105 *Acta Psychiatrica Scandinavica* 384.

eventual loss of their own autonomy is the primary predictor directed by their own awareness of the stigma associated with people experiencing mental illness.⁴⁹

The review of the education characteristic found that there was strong evidence that negative attitudes are negatively associated with educational attainment. Of the 38 studies in which education was a variable factor, 20 demonstrated that a positive relationship existed between educational level and the attitudes towards people experiencing mental illness. Most telling was that the more highly educated respondents tended to distance themselves less, and were more liberal in their views, but were also more accepting of compulsory admission.⁵⁰ However, almost an equal number of studies (18) reported that there was no relationship between negative attitudes and education at all.⁵¹

Of the 61 studies that included the characteristic of familiarity with mental illness, i.e. personally have, or have had a mental illness, or who have had personal contact with someone who has a mental illness, it was reported in half (30) of studies that people had more positive attitudes. An equal number of studies (30) found, however, that there was no association at all between familiarity and attitudes. The final study reported the greater familiarity with mental illness the person had, the more negative their attitudes. It established that in general, the willingness to react prosocially increased in proportion to the intensity of the exposure to mental illness, and did so across all groups of respondents including those dealing with the a person experiencing mental illness on a professional or volunteer basis. The exception to the rule was the group of respondents who themselves had undergone psychiatric treatment. This group chose to increase their social distance.⁵²

Major and O'Brien proposed that mental illness stigma is relationship and context specific: it does not reside in the person but rather within a specific social context.⁵³ Stigma can affect the stigmatised via the activation of negative in-group stereotypes

⁴⁹ Whatley, above n 46.

⁵⁰ Lauber, above n 48.

⁵¹ Ibid.

⁵² Matthias C Angermeyer and Herbert Matschinger "The effect of personal experience with mental illness on the attitude towards individuals suffering from mental disorders" (1996) 31 *Social Psychiatry and Psychiatric Epidemiology*, 321.

⁵³ Brenda Major and Laurie T O'Brien, 'The Social Psychology of Stigma' (2005) 56 *Annual Review of Psychology* 393.

that can lead to behaviour that assimilates to the stereotype.^{54 55} Even in the absence of discriminatory behaviour on the part of others, behaviour can be affected as a result of the associative linkages in memory between stereotypes and the behaviours they imply. Activating stereotypes can produce stereotype-consistent behaviour through an ideomotor process,⁵⁶ even among people who are not members of the group, so long as they are aware of the stereotype; the stereotype is activated in a situation; and the stereotype is applicable to the behavioural domain.⁵⁷ This phenomenon is seen in the family cases discussed in Chapter Six at 6.1. Acting bizarrely is a sufficient indicator for some decision-makers that a party has a mental illness even though the expert medical evidence presented to the court clearly states that they do not.

Drawing from the theoretical and practical experience literature, numerous stigma reducing and discrimination decreasing stratagems have been advanced. Interpreting this evidence, it appears that short term, specialist education programs featuring the element of contact which are directed toward young university students have the best chance of changing attitudes, reducing stigma and decreasing discrimination. One program that satisfies these characteristics is the Mental Health Tribunal Representation Scheme. It is discussed in Chapter Seven and its value in positively changing attitudes is evaluated in Chapter Eight. However, the evidence base supporting prejudice and stigma change is underdeveloped, which makes speaking authoritatively on the most effective change practices impossible.⁵⁸ The complexity of mental illness stigma, the broad spectrum of the different types of interventions undertaken, the different desired program outcomes of changing knowledge, changing attitudes or changing behaviours, the different target groups receiving intervention, the scale of intervention and the different evaluation measures used all converge to complicate comparisons across studies. Further research that better sets down an empirical basis for planning evidence-based

⁵⁴ John A Bargh, Mark Chen and Lara Burrows, 'Automaticity of social behavior: direct effects of trait construct and stereotype activation on action' (1996) 71 *Journal of Personality and Social Psychology* 230.

⁵⁵ Ap Dijksterhuis *et al.*, 'On the relationship between associative strength and automatic behaviour' (2000) 36 *Journal of Experimental Social Psychology* 531.

⁵⁶ S Christian Wheeler, W Blair G Jarvis and Richard E Petty, 'Think unto others: the self-destructive impact of negative racial stereotypes' (2001) 37 *Journal of Experimental Social Psychology* 173.

⁵⁷ Major and O'Brien, above n 56.

⁵⁸ George N Christodoulou (ed), *Advances in psychiatry*, Vol. 2. (World Psychiatric Association, 2005), Helen Stuart and Norman Sartorius, Fighting stigma and discrimination because of mental disorders, 79.

interventions to correct mistaken beliefs about mental illness and positively alter attitudes toward people experiencing mental illness is essential.^{59 60}

8. DEVELOPMENT OF THESIS

The thesis contains eight chapters. Chapter One identifies the conceptual and definitional problems that have confused and confounded the development and implementation of clear and consistent mental health policies across Australian jurisdictions. Even at the international level, ‘mental health’ lacks clear definitions and conceptual agreement and is subject to different interpretations and inconsistent applications. This is demonstrated in the results of the author’s previous original research assessment of the compliance of Australia’s mental health acts with international human rights requirements. This data has been updated by the author’s review of the legislative changes that have occurred during the intervening five year period.

It examines the development of aspirational public mental health policies that focus on the social well-being of the individual, and are intended to change how society responds to the person’s needs and interests. It explores this paradigm shift away from the previous wholly person-centric medical model policy approach to mental illness toward the socially inclusive, disability approach that identifies social situations as the real cause of discrimination and prejudice. It continues on to explain that these policies have had little impact on altering the general expectation that it is the person who must internally change by taking medication to stop the manifestations of their socially unacceptable behaviours. To this end, the law is an important public health tool used to strongly reinforce the social want to ‘control and treat’. Despite the lofty intentions of contemporary mental health policies, competing and conflicting paradigms, vagaries, ideological differences, and language deficiencies have meant that they have had little influence on reducing the stigma associated with mental illness.

⁵⁹ Ibid 82.

⁶⁰ Thomas P LeBel, ‘Perceptions of and responses to stigma’ (2008) 2 *Sociology Compass* 409.

Chapter Two discusses similar conceptual and definitional problems associated with what ‘mental illness’ means apparent in law. It shows that the law has wholly incorporated the biomedical notions of mental illness, and the generalised, broad, vague, ambiguous, and circular treatment it has given to what it actually means has permitted and masked the arbitrariness and discrimination in the law’s application. The flawed and unreliable diagnostic process that clinically labels an individual as ‘mentally ill’ makes them vulnerable to the prejudices and discriminations in the legal system, rooted as it is in the medical model of treatment and control, and reliant on psychiatric predictions of risk and future behaviour of the individuals to which the system has been forewarned, possess characteristics of unreliability, incredibility, unpredictability and dangerousness.

Chapter Three is important because it explores the phenomenon of stigma, a construct that is best understood in terms of its three components: stereotypes, prejudice and discrimination. It discusses how these components combine in the context of social power to devalue human characteristics and perpetuate social inequality. It explains the historical factors of deinstitutionalisation and drug therapy advancements that led social scientists to begin investigating the public’s attitudes to people experiencing mental illness. It presents the major stigma theories and demonstrates the existence of the implicit association of mental illness with the moral concepts of ‘helpless’, ‘bad’ and ‘blameworthy’ which inextricably links the public’s loathing of mental illness with its fear of violence. It discusses structural prejudicial attitudes and discriminatory practices found in the legal system.

Chapter Four explores the policy and legal efforts to reduce the stigma associated with mental illness. It discusses the public health disease approach to altering the public’s negative attitudes by improving its mental health literacy, and convincing it that mental illness is an ‘illness like any other’. It examines the ideology of political correctness and the enactment of anti-discrimination laws. These strategies seek to eliminate prejudice and discrimination by altering society’s informal and formal rules, thereby, effecting positive change in public thought, language and behaviour. The impact that these measures have had on reducing mental illness stigma has been limited, which may be a reflection of the complex relationship between negative attitudes and the wrong behaviours that they drive.

Stigma is an expression of society's intolerance toward difference, its rejection of abnormality, and a justification for the authoritarian and benevolent responses of intimidation, coercion, humiliation and exclusion directed toward people who are stereotypically categorised as weak, irrational, unpredictable, dangerous and inferior. The chapter shows that statutes and administrative directives, commonly viewed as tools for righting the injustices of structural stigma have, in fact, had the unanticipated effect of reinforcing public stereotypes and prejudices, and promoting further disadvantage to people experiencing mental illness that are brought into contact with the legal system.

Chapter Five explores the dualistic concepts of sanism and pretextuality which, according to Michael Perlin, permeates mental health law. It explores sanism and stigma which, although conceptually different, possess the same irrational prejudices, making distinguishing them from each other difficult. Sanism which Perlin describes is the specific prejudice associated with mental illness is the construct of stigma but unlike other 'isms' such as racism and sexism, it is a prejudice that is both largely invisible and socially acceptable because it is embedded within society's beliefs and attitudes, language and humour.

Chapter Five also examines sanism's connective concept pretextuality; the term Perlin uses to describe the corrupted legal processes that he argues infects the legal system. Legal actors interpret and accept information based on their own sense of morality and their personal sense of justice, or what is right. The law is applied through pretexts. Data is distorted and evidence is suppressed. Courts willingly accept false or misleading testimony and engage in superficial or dishonest decision-making. Sanism and pretextuality are used in combination to achieve a desired social result rather than offer a fair legal outcome to parties experiencing a mental illness.

Chapter Six lays the lens of sanism, stigma and discrimination over the family law system. It explores the controversial claims of Perlin that were discussed in Chapter Five through an examination of decision-making in child protection and family law matters when a parent has a mental illness. It demonstrates that these parents are widely stigmatised as incapable of 'good parenting'. They are labelled as harmful to the safety and healthy development of their children.

Chapter Six assesses the different and often conflicting risk of harm thresholds used by the child protection and court systems to control unsuitable and undesirable parenting. It shows that when a parenting matter is brought before a court that it is required to assess the parent's parenting skills and to measure the risk of harm that they represent to their child's well-being, the court's interpretation of its obligation to protect children 'at risk' often results in a parent who has experience of a mental illness being viewed as an 'unacceptable risk'. Once tagged with this label, it is likely that they will have their parental responsibilities severely restricted, or will lose them altogether.

These practical legal repercussions of parental mental illness are discussed in the perustration of Australia's primary family law legislation, the Family Law Act 1975. This shows that courts interpret statutory concepts such as the 'best interests of the child' and 'meaningful relationship' by using the adversity approach which is inherent in the social science research, and fundamental to the social-scientific risk assessment tools.

Chapter Six continues on to present the results of an original investigation of 296 Australian family law parenting orders made between 2006 and 2011. The case studies confirm that courts do label, stereotype and discriminate in circumstances where a parent has experience of mental illness. Even in situations where there is clear medical evidence provided to the court that the parent does not have a mental illness, some courts appear willing to disregard the non-diagnosis as a failure on the part of the experts: they were deceived and manipulated by the 'mentally ill parent. And contrary to the medical evidence, courts imply that the parent is 'mentally ill' because it determines the demeanour or behaviour of the parent is unacceptable measured against the judge's personal measure of suitable expectations of mental normality. The implication of the parent's mental illness justifies the judicial decision to restrict or remove parental responsibilities because in matters concerning a child, it is a risk that the courts are loathed to take.

The first six chapters examine the reality of what stigma and sanism are, and explores the negative impact that they have on the vulnerable, marginalised and disempowered groups in society. Human beings are motivated to defend and justify the prevailing social, economic and political norms which they class as good,

legitimate and desirable even when inequality is perpetrated and ‘Others’ are disadvantaged. Stereotypes are used to categorise the group as different and less worthy so that the inequalities, unfairness and disadvantage can become invisible or acceptable. Stereotypical, prejudicial and discriminatory beliefs about mental illness are evident in the policies and laws that societies create, enact, interpret and act on. Prejudice and intolerance are human failings from which, as Perlin states, the legal system is not immune.

As Perlin contends, the legal system is sanist but it is people who are at the system’s core and sanism is a disease of attitudes. Chapter Seven presents as one option for change, the Mental Health Tribunal Representation Scheme (MHTRS) which has the potential to heal the disease while future lawyers are still in school. The MHTRS is a short term, structured, therapeutic jurisprudence clinical legal education program that combines appropriate mental health education with a contact stratagem. It is a best evidence approach to positively changing the attitudes of law students while meeting the need for legal representation for clients appearing before mental health tribunals and boards of review. Debunking myths and stereotypes and providing opportunities for personal contact with people who have a mental illness, has the potential of helping future policy-makers, legislators, judges, lawyers and legal administrators to break down the legal system’s sanist barriers from within.

Chapter Eight is an empirical chapter that quantitatively tests the level of attitudinal prejudice that law students have on entering university law studies. It compares the data against that data collected from the group of final year law students exiting law school. The comparative analysis focuses on differences of gender and personal experience of mental illness. It also assesses the impact that students’ participation in the MHTRS has on attitudes. To the best of the author’s knowledge, this is the first attempt to reliably validate some of the attitudinal assertions Perlin has made over the years. Although the results of the study did not return many significant results, it has laid the groundwork for future research on this topic. If a reduction in stigma, and a decrease in the discriminations experienced by people who have a mental illness when they come into contact with the legal system are to occur, it is important that strategies are developed, tested, implemented and evaluated that

tackle the sanist myths and stereotypes held by the young and ideological new generation of legal professionals.

The thesis concludes with a discussion of the main points made throughout the paper. It summarises the major concepts examined in each chapter. It then presents the major findings of the empirical study that examined the attitudes of 285 law students from the University of Tasmania. Finally, it sets out the recommendations that have been reached at the conclusion of this dissertation titled ‘Sanism, a socially acceptable prejudice: addressing the prejudice associated with mental illness in the legal system’.

BIBLIOGRAPHY

A. Articles

Alexander, Laurel A, and Bruce G Link, 'The impact of contact on stigmatizing attitudes towards people with mental illness' (2003) 12 *Journal of Mental Health* 271.

Angermeyer, Matthias C, Beate Schulze and Sandra Dietrich, 'Courtesy stigma: A focus group study of relatives of schizophrenia patients' (2003) 38 *Social Psychiatry and Psychiatric Epidemiology* 593.

Angermeyer, Matthias, and S Deitrich, 'Public beliefs about and attitudes towards people with mental illness: a review of population studies' (2006) 113 *Acta Psychiatrica Scandinavica* 163.

Angermeyer, Matthias C, and Herbert Matschinger, 'The effect of personal experience with mental illness on the attitude towards individuals suffering from mental disorders' (1996) 31 *Social Psychiatry and Psychiatric Epidemiology*, 321.

Bargh, John A, Mark Chen and Lara Burrows, 'Automaticity of social behavior: direct effects of trait construct and stereotype activation on action' (1996) 71 *Journal of Personality and Social Psychology* 230.

Corrigan, Patrick W, and Amy C Watson, 'Understanding the impact of stigma on people with mental illness' (2002) 1 *World Psychiatry* 16.

Corrigan, Patrick W, and David L Penn, 'Lessons from social psychology on discrediting psychiatric stigma' (1999) 54 *American Psychologist* 765.

Corrigan, Patrick W, Fred E Markowitz and Amy C Watson, 'Structural Levels of Mental Illness: Stigma and Discrimination' (2004) 30 *Schizophrenia Bulletin* 481.

Corrigan, Patrick W, *et al.*, 'Challenging two mental illness stigmas: Personal responsibility and dangerousness' (2002) *Schizophrenia Bulletin* 293.

Crisp, Arthur H, *et al.*, 'Stigmatisation of people with mental illness' (2000) 177 *British Journal of Psychiatry* 4.

Dijksterhuis, Ap, *et al.*, 'On the relationship between associative strength and automatic behaviour' (2000) 36 *Journal of Experimental Social Psychology* 531.

Gordon, Phyllis A, *et al.*, '"Attitudes regarding interpersonal relationships with persons with mental illness and mental retardation' (2004) 70 *Journal of Rehabilitation* 50.

Kerr, Norbert L, Robert J MacCoun and Geoffrey P Kramer, 'Bias in Judgment: Comparing Individuals and Groups' (1996) 103 *Psychological Review* 687.

Large, Matthew and Christopher J Ryan, 'Sanism, stigma and the belief in dangerousness' (2012) 46 *Australian & New Zealand Journal of Psychiatry* 1099.

Lauber, Christoph, *et al.*, 'Public Attitude to compulsory admission of mentally ill people' (2002) 105 *Acta Psychiatrica Scandinavica* 384.

LeBel, Thomas P, 'Perceptions of and responses to stigma' (2008) 2 *Sociology Compass* 409.

- Link, Bruce G, *et al.*, 'Measuring Mental Illness Stigma' (2004) 30 *Schizophrenia Bulletin* 511.
- Major, Brenda, and Laurie T O'Brien, 'The Social Psychology of Stigma' (2005) 56 *Annual Review of Psychology* 393.
- Perlin, Michael L, 'His Brain Has Been Mismanaged with Great Skill': How Will Jurors Respond to Neuroimaging Testimony in Insanity Defense Cases?' (2009) 42 *Akron Law Review* 885.
- Phelan, Jo C and Bruce Link, 'Conceptualizing Stigma' (2001) 27 *Annual Review of Sociology* 363.
- Perlin, Michael L, "'Things Have Changed:' Looking At Non-Institutional Mental Disability Law Through The Sanism Filter' (2003) 46 *New York Law School Law Review* 535.
- Perlin, Michael L, 'Simplify You, Classify You: Stigma, Stereotypes and Civil Rights in Disability Classification Systems' (2008/09) 25 *Georgia State University Law Review* 607.
- Phelan, Jo C, Bruce G Link and John F Dovidio, 'Stigma and prejudice: one animal or two?' (2008) 67 *Social Science and Medicine* 358.
- Poole, Jennifer M, *et al.*, 'Sanism, 'Mental Health', and Social Work/Education: A Review and Call to Action' (2012) 1 *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice* 20.
- Porter, Stephen, Leanne ten Brinke and Chantal Gustaw, 'Dangerous decisions: the impact of first impressions of trustworthiness on the evaluation of legal evidence and defendant culpability' (2010) 16 *Psychology, Crime & Law* 477.
- Reinke, Rebecca, *et al.*, 'Examining Two Aspects of Contact on the Stigma of Mental Illness' (2004) 23 *Journal Of Social And Clinical Psychology* 377.
- Sartorius, Norman, 'Iatrogenic stigma of mental illness' (2002) 324 *British Medical Journal* 1470.
- Sayce, Liz, 'Stigma, discrimination and social exclusion: What's in a word?' (1998) 7 *Journal of Mental Health* 331.
- Schumacher, Matthew, Patrick W Corrigan and Timothy Dejong, 'Examining cues that signal mental illness stigma' (2003) 22 *Journal of Social and Clinical Psychology* 467.
- Stuart, Heather, 'Fighting the stigma caused by mental disorders: past perspectives, present activities, and future directions' (2008) 7 *World Psychiatry* 185.
- Szasz, Thomas, The myth of mental illness (1960) 15 *American Psychologist* 113.
- Thornicroft, Graham, *et al.*, 'Stigma: ignorance, prejudice or discrimination?' (2007) 190 *British Journal of Psychiatry* 192.
- Whatley, Charles D, 'Social Attitudes Toward Discharged Mental Patients' (1959) 6 *Social Problems* 13, 316 – 317.
- Wheeler, S Christian, W Blair G Jarvis and Richard E Petty, 'Think unto others: the self-destructive impact of negative racial stereotypes' (2001) 37 *Journal of Experimental Social Psychology* 173.

B. Books

Christodoulou, George N, (ed) *Advances in psychiatry*, Vol. 2. (World Psychiatric Association, 2005) Helen Stuart and Norman Sartorius, *Fighting stigma and discrimination because of mental disorders*, 79.

Corrigan, Patrick W and Amy C Watson, *The paradox of self-stigma and mental illness* (Clinical Psychology: Science and Practice, 2002).

Corrigan, Patrick W, *On the Stigma of Mental Illness* Washington (American Psychological Association, 2005).

Goffman, Erving, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Doubleday & Co. Anchor Books, 1961).

Goffman, Erving, *Stigma: notes on the management of spoiled identity* (Prentice-Hall, 1963).

Gramsci, Antonio, *Selections from the Prison Notebooks of Antonio Gramsci*: (Quentin Hoare and Geoffrey Nowell Smith editors and translators), (International Publishers, 1971).

Macquarie Dictionary (Macquarie University Press, 5th ed, 2009).

Rawls, John, *A Theory of Justice* (Harvard University Press, 1971).

Scheff, Thomas J, *Being mentally ill: a sociological theory* (Weidenfeld & Nicolson, 1967).

Stuart, Heather, Julio Arboleda-Florez and Norman Sartorius, *Paradigms Lost: Fighting Stigma and the Lessons Learned* (Oxford University Press, 2012).

Parry, John D, *Criminal Mental Health and Disability Law, Evidence and Testimony: A Comprehensive Reference Manual for Lawyers, Judges and Criminal Justice Professionals* (American Bar Association, 2009).

Perlin, Michael, *The Hidden Prejudice: Mental Disability on Trial* (American Psychological Association, 2000).

Spitzer, Stephan P and Norman K Denzin (eds) *The mental patient* (McGraw-Hill, 1968) Erving Goffman, *The moral career of the mental patient*, 226.

C. Grey Literature - Research Papers, Reports, Submissions, Letters, Memos etc.

Ingram, Richard, 'Sanism in Theory and Practice' (Workshop, 2nd Annual Critical Inquiries, 9-10 May 2011) <http://www.socialinequities.ca/wordpress/wp-content/uploads/2011/07/Ingram.Sanism-in-Theory-and-Practice.CI_.2011.pdf>.

Perlin, Michael L, *'They're An Illusion to Me Now': Forensic Ethics, Sanism and Pretextuality* (Research Paper No 07/08 # 27, New York Law School Legal Studies, 2008) <<http://ssrn.com/abstract=1130923>>.

Snow, Kathie, 'People First Language' (2008) <http://www.acdd.org/wp-content/uploads/2011/01/People_First_Language.pdf>.

'What is Mental Illness', Mental Health and Workforce Division of the Australian Government Department of Health and Ageing, <http://www.dhhs.tas.gov.au/___data/assets/pdf_file/0003/38442/what_is_mental_illness.pdf>.

White, William, 'The Rhetoric of Recovery Advocacy: An Essay on the Power of Language' (Research Paper, 2001) <<http://naabt.org/documents/LANGUAGEBillWhite.pdf>>.

CHAPTER ONE

MENTAL HEALTH: AN AREA OF CONCEPTUAL AND DEFINITIONAL CONFUSION

1. INTRODUCTION

In recent decades, mental health has developed into a public health industry, albeit, an industry beset by problems of competing and conflicting paradigms, ideological differences, and language deficiencies. It has become the global domain of policy-makers that use aspirational language for its rhetorical power to achieve social objectives rather than offering any real interpretive value. Although intrinsically concerned with the detrimental impact that mental illness has on the physical, emotional and social well-being of the individual and their community, policy-makers have taken a somewhat apathetic approach toward the development of a single, clear and coherent mental health model.

Australian policy makers have substantially failed to address the botherations associated with public mental health policies globally; initiate a unified approach to overcoming the jurisdictional divides; or establish a pattern of unambiguous and consistent messaging. Instead of turning their attention to developing a unique, clear, precise, ideologically appropriate mental health model, policy makers are increasingly turning to the disability health model, a model that suffers from its own particular vagaries and definitional limitations. It is a model that appears ideologically incompatible, inadequate, and incongruous with meeting the needs of people experiencing mental illness.

Chapter One is contextually important to the thesis because it presents an entry portal into the poorly defined and conceptually confused mental health policy area that is the foundation on which the law stands, and relies. It undertakes a comparative examination of Australia's recent primary mental health policy documents. The results demonstrate that the social model approach to mental health has made inroads into policy development. It has overtaken, in some

jurisdictions, the psychosocial model, which has itself challenged the absolute dominance of the biomedical model. But rather than taking a unified approach toward superseding current, outdated models with a paradigm better able to meet the contemporary and future needs and interests of individuals and society,¹ policy-makers have created a mental health environment in which different models must co-exist.²

The chapter contrasts the positive acceptance of health and wellbeing as desirable attributes against the negative perception of mental health as disease and illness. It discusses the effectiveness of the population health approach to mental health. Although health is recognised as a positive and desirable human attribute, health promotion, and the social agenda of recent mental health policies have not significantly altered the view of mental health as a negative concept, rooted in abnormality which, as a state of being, is a highly undesirable human condition. This concept is discussed more fully in the following chapter while Chapter Three discusses how stigma associated with mental illness has, in fact, increased despite the prolific output of public policies intent on its reduction.

Mental health policies represent a government or organisation's commitment to actively address issues of mental ill health within its population. It requires a concurrent commitment to provide sufficient human and financial resources so as to achieve the intended outcomes. This has not occurred. There has been an inability, and/or a reluctance to implement the newly favoured social model approach of mental health policies into clinical operational practice. Unlike the physical and social impairment origins of the disability paradigm, mental health has the medical model of treatment and care at its centre. According to this model, when funding is limited, prioritisation is given to treatment and hospitalisation.³ Policies that focus on issues outside this traditional view of mental health's medical 'core business' have little impact on operational practices in what is the permanently inadequately funded and resourced mental health sector. Without adequate financial

¹ Thomas S Kuhn, *The Structure of Scientific Revolutions* (The University of Chicago Press, 2nd ed, 1970).

² Jerry Tew (ed), *Social Perspectives in Mental Health: Developing Social Models to Understand and Work with Mental Distress* (Jessica Kingsley Publishers, 2005).

³ Most countries spending less than 1% of its health budget on mental health; The World Health Organisation, 'The World Health Report 2001 – Mental Health: New Understanding, New Hope' (Report, WHO, 2001) <http://www.who.int/whr/2001/en/whr01_en.pdf>.

commitment, a social policy, regardless of its quality, cannot be effective in changing negative attitudes if it is given limited practical application.

A perustration of Australian mental health policies exposed theoretical and definitional inconsistencies among the Commonwealth's own policies. Also identified were inadequacies in state and territory mental health acts regarding their compliance with human rights requirements laid down in international instruments such as the *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*⁴ and the *Convention on the Rights of Persons with Disabilities*.⁵ Even at the international level, mental health policies lack clear definitions and conceptual agreement, and are subject to different interpretations and inconsistent applications.⁶

The term 'mental health' is itself, a euphemism for 'mental illness', 'mental disorder', 'mental disease', 'psychiatric illness' and 'psychiatric disability'. The terms are used interchangeably as synonyms,⁷ as much in public policy documents as in public conversation, to explicate the socially unacceptable behaviours of people stereotyped as irrational, incompetent and dangerous. They are descriptors that aid in the identification of the 'them' social group which belongs outside, and away from the 'us' group, a topic discussed in more detail in Chapter Three.

A research question addressed in Chapter Eight is whether the attitudes of law students who have participated in a short, structured clinical legal program founded on the principles of therapeutic jurisprudence are positively influenced by the experience. According to Michael Perlin⁸, the legal system is inherently biased against mental illness. He argues that lawyers commonly provide incompetent representation in matters in which mental illness is a pertinent factor⁹; legislators enact laws that promote the differentness of people experiencing mental illness;¹⁰

⁴ *Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, GA Res 46/119, UN GAOR, 75th plen mtg, UN Doc A/RES/46/119 (17 December 1991).

⁵ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007 adopted by the General Assembly by resolution A/RES/61/106 ratified by Australia 17 July 2008.

⁶ Lance Gostin, 'Human Rights of Persons with Mental Disabilities: The European Convention of Human Rights' (2000) 23 *International Journal of Law and Psychiatry* 125.

⁷ R E Kendell, 'The distinction between personality disorder and mental illness' (2002) 180 *The British Journal of Psychiatry* 110, 111.

⁸ Michael L Perlin, *The Hidden Prejudice: Mental Disability on Trial* (American Psychological Association, 2000) 55.

⁹ *Ibid* 50.

¹⁰ *Ibid* 48.

judges deliver unfair rulings; and legal academics largely ignore reporting on the legal system's unsatisfactory practices¹¹ because they are all ignorant to their own prejudices which are hidden behind a curtain of social acceptance.

A first step in lifting the curtain of acceptance that hides the legal system's prejudice is to expose the complexities, confusions and vagaries that exist in the mental health policy area. These problems provide evidence for; contribute to; and maintain the presence of stigma and discriminations associated with mental illness. Mental health policies have failed to provide the legal system with a strong guiding platform from which the law can best interface with mental illness, bring about social change¹² and ensure that people experiencing mental illness are not disadvantaged when they come into contact with the legal system.

2. THE CONCEPT OF HEALTH

HEALTH		
BIOLOGICAL	SOCIOLOGICAL	PSYCHOLOGICAL

The concept of health is viewed as a positive, valued and desired attribute¹³: a priceless and indispensable element of living.¹⁴ It is characterised as a concurrence of the physical, psychological, and social although there is some concern that the words 'physical', 'mental' and 'social well-being' indicate the 'need for economic, social, political and judicial influences that are way beyond those of health professionals.'¹⁵ Public health policies strive to attain healthier lives for populations by preventing disease through education and regulation and promoting healthier lifestyles. The importance given to health as a desirable human value is sufficiently weighted that it displaces, in the balance, the rights of adult, rational citizens to make decisions regarding behaviours that would not otherwise be subject to political and legal intervention.

¹¹ Ibid 56.

¹² Gerald N. Rosenberg, *The Hollow Hope: Can Courts Bring About Social Change?* (Second Edition) (University of Chicago Press, 2008)

¹³ Christopher Boorse, 'Health as a Theoretical Concept' (1977) 44 *Philosophy of Science* 542.

¹⁴ Alvin Concha *et al.*, 'Concept Of Health And Health Needs Of Suburban Residents In A Developing Country: Qualitative Study' (2003) 2 *Asia Pacific Family Medicine* 107.

¹⁵ Saxby Pridmore, *Download of Psychiatry*, Chapter 32. Chapter 32, p.2, <http://eprints.utas.edu.au/287/40/Chapter_32__Medicalization_of_suffering.pdf >

In 1948, the World Health Organization's (WHO) Constitution defined health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.¹⁶ This was a new, transformative definition that offered a world vision of health for everyone. The meaning was extended beyond the prevailing negative medical concept of health at the time - the absence of disease¹⁷ - to the attainment of a positive state of complete well-being. WHO would later expand the meaning even further by stating that health was 'a positive concept emphasising social and personal resources, as well as physical capacities'.¹⁸

WHO listed the fundamental conditions and resources necessary for achieving and maintaining health: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity.¹⁹ It acknowledged that if this expression of community health was to be achieved and maintained, legislators and policy-makers had to ensure that laws and policies were put in place that emphasised an individual's social well-being rather than focusing on the medical concepts of disease, illness and treatment objectives. While Australia's health policies largely reflect this focus change, Australian mental health laws remain mired in the medical concepts of disease, illness and treatment objectives.

The current positivist sense of health may be classed as an ideal of presumptive good, framing what are normatively accepted as appropriate behaviours, and setting the standard for internal and external assessments of personal well-being and effective functioning. To be situated within this state of health is a desired human value of the highest order.²⁰ This end value is achieved and maintained by relying on lesser values such as the provision of health care by skilled and knowledgeable professionals; access to well-resourced and well-equipped health facilities and services; and health services that satisfy a wide range of needs including cultural and social interests that extend beyond merely the pathological. This ideal is rarely

¹⁶ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948.

¹⁷ Boorse, above n 13.

¹⁸ Ottawa Charter for Health Promotion First International Conference on Health Promotion, Ottawa, 21 November 1986 - WHO/HPR/HEP/95.1

<<http://www.who.int/healthpromotion/conferences/previous/ottawa/en/>>

¹⁹ Ibid.

²⁰ Michael J. Stahl (ed), *Encyclopedia of health care management* (Sage Publications, 2004) 123.

achieved in practice as health systems commonly suffer from funding and resourcing deficiencies which lead to access and service restrictions.

From the vantage of the goodness and desirability of health, illness is viewed as stemming from the medical concept of ‘disease’ which is a pathologically abnormal condition, and culturally, highly undesirable.²¹ Disease is a negative attribute, and being ill results in the ‘temporary’ suspension of well-being: a period of lapse from the norms and directions of a healthy society will exist.²² Deviation from the health norm brings with it external value judgments regarding the person’s physical and mental capacity, decision-making abilities, vulnerability, and level of responsibility.²³ These are matters that are often determined within the legal framework of protection and control legislation such as guardianship,²⁴ mental health²⁵ and drug and alcohol²⁶ legislation. Mental health is largely associated with illness and disease, abnormality, and fear and avoidance.

2.1 Population health

The term, ‘population health’ lacks a clear understanding of its meaning and scope.²⁷ It does not have a specific definition although public policies and academic articles commonly replicate the vastly altered definition of public health eugenicist, C.E.A. Wilson, as ‘the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals.’²⁸ Public health systems have adopted a dichotomous policy approach of prevention and population health. Preventative policy efforts seek to eliminate factors that cause or contribute to illness while population health seeks to enhance existing health by focusing on individual and community strengths.²⁹

²¹ Juha Räikkä, ‘The social concept of disease’ (1996) 17 *Theoretical Medicine and Bioethics* 353, 354.

²² Ibid 357.

²³ Ibid 356.

²⁴ *Guardianship and Administration Act* 1995 (Tas).

²⁵ *Mental Health Act* 1996 (WA).

²⁶ *Alcohol and Drug Dependency Act* 1968 (Tas).

²⁷ David Kindig and Greg Stoddart, ‘What Is Population Health?’ (2003) 93 *American Journal of Public Health* 380.

²⁸ C E A Wilson, ‘The untilled fields of public health’ (1920) 51 *Science* 23, 30.

²⁹ Bonnie Pape and Jean-Pierre Galipeault, ‘Mental Health Promotion for People with Mental Illness’ (Discussion Paper, Mental Health Promotion Unit of Health Canada, April 2002) <http://www.phac-aspc.gc.ca/publicat/mh-sm/mhp02-psm02/pdf/mh_paper_02_e.pdf>.

Population health is generally regarded as a ‘conceptual framework for thinking about why some populations are healthier than others as well as the policy development, research agenda, and resource allocation that flow from this framework.’³⁰ Rose proposed that the most efficient way to prevent health problems in the individual is to reduce the whole population’s level of risk.³¹ Achieving this outcome of improved health and well-being requires a multiphase approach with the development of public health policies that first, build public consensus and an authorising environment, identify the problem, increase knowledge from research and experience, create public awareness, and set a national agenda.³²

The distinction between population health and mental health promotion is even less clear. ‘Population health focuses on the range of conditions that determine health and their impact on the population in general, viewed through various life stages, and addressed through intersectoral strategies.’³³ Mental health promotion is concerned with participation and the impacts of social/environmental factors on health but, unlike population health, it stresses individual and community control over mental health concerns.³⁴

The recent trend of naming specific life conditions as a disease in the social sense of the word has caused some concern regarding the ‘medicalisation of life’³⁵, a phenomenon that had its policy genesis in WHO’s broad definition, a topic discussed in more detail in Chapter Two. This new social sense of disease has triggered a concomitant belief that particular public health practices or actions are justified, even obligatory.³⁶

Categorising and labelling people as alcoholics, gamblers, drug users and tobacco users for example, marks them as different, suffering from a disease, and ill, all of which are conditions that impose on the state an obligation to intervene in the person’s life. It does this via its combined political, medical, and legal institutions

³⁰ T Kue Young, *Population Health: Concepts and Methods* (Oxford University Press, 1998) 4.

³¹ Geoffrey Rose, *The Strategy of Preventive Medicine* (Oxford University Press, 1993).

³² Alvin R Tarlov, ‘Public Policy Frameworks for Improving Population Health’ (1999) 896 *Annals of the New York Academy of Sciences* 281.

³³ Pape and Galipeault, above n 29, 6.

³⁴ *Ibid.*

³⁵ Peter Conrad and Kristin K Barker, ‘The Social Construction of Illness: Key Insights and Policy Implications’ (2010) 51 *Journal of Health and Social Behavior* 67.

³⁶ Räikkä, above n 21, 357.

to direct them back toward experiencing healthy well-being, and equally, to prevent others falling victim to ill health.

3. THE CONCEPT OF MENTAL HEALTH

Whether we like it or not, the term mental health ... is firmly established in the thought and actions of several groups: First, under the guidance of voluntary and governmental agencies, the public has taken hold of the term in spite of (or, perhaps, because of) its ambiguity.³⁷

Generally, 'mental health' refers to the enhancement of the state of mental well-being in an already well population.³⁸ However, the level of clear scientific guidance that is present in general health tends to be absent in the mental health sector where terms are more fluid, lack clear delineation, and are generally used synonymously. There also seems to be a conceptual and textual avoidance existing in mental health, a likely product of the complexity of the subject matter but it may also be a reflection of the stigma that permeates the topic area.

The term 'mental health' is itself a theoretical construction of governments, mental health professionals, families, and other interested groups such as the powerful drug lobby to place a positive spin on the negative attributes of disease and illness.³⁹ By euphemising terms, the public perception that mental illness is a cause for shame, and needs to be hidden, or disguised to make it more socially palatable is reinforced. Confused, deficient and false assumptions contribute to the inconsistencies and vagaries of language and concepts that are apparent in mental health discussion.

Unlike the polar opposites of illness and health in general health parlance, in mental health the terms 'mental illness' and 'mental health' are conceptually blurred. Using the standard health model as a reference guide, mental illness is an umbrella, psychopathological term that covers a range of mind-related diseased states with a broad spectrum of behavioural disturbances: mental disorders. The social approach

³⁷ Marie Jahoda, *Current Concepts of Positive Mental Health* (Ayer Company Publishers, 1999) 5.

³⁸ Jayashri Kulkarni, 'The Cost of Mental Illness' (Report, Monash Alfred Psychiatry Research Centre, 2010) 1 <http://www.maprc.org.au/sites/www.maprc.org.au/files/THE%20COST%20OF%20MENTAL%20ILLNESS%20FINAL_0.pdf>.

³⁹ Katherine Weare, *Promoting mental, emotional, and social health: a whole school approach* (Routledge, 2000).

to mental health, a topic discussed more fully in 4.0, views a ‘mental disorder’ as a product of society’s failure to ensure adequate and appropriate services that meet the needs of people who experience a mental illness. Although, arriving at a positive or precise definition of mental disorder using the social standard is difficult.⁴⁰

In Australia, the combined civil, criminal and administrative processes relevant to the legal rights of, and impositions on, people experiencing mental illness is known as mental health law.⁴¹ Clinical, rehabilitation and support services are called mental health services.⁴² Hospitals, community treatment centres and other service delivery locations are called mental health facilities. Statutes authorising involuntarily detention and treatment are called mental health acts.⁴³ Psychiatrists, psychologists, psychiatric nurses and allied health staff working directly with the symptoms and behaviours caused by a mental disorder are called mental health professionals. The person experiencing a mental illness is a mental health patient, a person labelled as ill, suffering, in need of medical treatment, and potentially requiring intervention and control by the state. There are few, if any positive attributes associated with the role of the mental health patient who is at the epicentre of mental health law.

3.1 Defining mental health

Mental health is described by WHO as a state of being in which an individual is able to realise their own abilities: cope with the normal stresses of life; and is able to work productively and fruitfully; and make a contribution to their community.⁴⁴

The mentally well person has:

the capacity to think rationally and logically, and to cope with the transitions, stresses, traumas, and losses that occur in all lives, in ways that allow

⁴⁰ Michael S King, ‘Solution-Focused Judging Bench Book’ (Report, The Australasian Institute of Judicial Administration Incorporated, 2009) 79.

⁴¹ In other countries such as the United States of America, it is called Mental Disability Law.

⁴² The definition of mental health services contained in the Fourth Mental Health Plan 2009-2014 states that it “Refers to services in which the primary function is specifically to provide clinical treatment, rehabilitation or community support targeted towards people affected by mental illness or psychiatric disability, and/or their families and carers. Mental health services are provided by organisations operating in both the government and non government sectors, where such organisations may exclusively focus their efforts on mental health service provision or provide such activities as part of a broader range of health or human services.” P.84

⁴³ The Tasmanian legislation is the *Mental Health Act 1996* (Tas).

⁴⁴ World Health Organization, *Strengthening Mental Health Promotion*. Geneva: World Health Organization (Fact Sheet, No. 220); 2001b.

emotional stability and growth. In general, mentally healthy individuals value themselves, perceive reality as it is, accept its limitations and possibilities, respond to its challenges, carry out their responsibilities, establish and maintain close relationships, deal reasonably with others, pursue work that suits their talent and training, and feel a sense of fulfilment that makes the efforts of daily living worthwhile.⁴⁵

An examination of Commonwealth mental health policy documents demonstrates the problems posed by existing definitional inconsistencies. The results of this policy survey indicate that arriving at a consensus Australian definition for mental health is unlikely because ‘such a complex and multifaceted concept in a short simple statement is just not appropriate or possible’.⁴⁶ Both the first National Mental Health Plan⁴⁷ and the Second National Mental Health Plan⁴⁸ broadly defined ‘mental health’ as:

the capacity of individuals and groups to interact with one another and the environment in ways that promote subjective well-being, optimal development and use of cognitive, affective and relational abilities, and the achievement of individual and collective goals consistent with justice.⁴⁹

The Third Plan, with far more verbosity, defined ‘mental health’ as:

A state of emotional and social wellbeing in which the individual can cope with the normal stresses of life and achieve his or her potential. It includes being able to work productively and contribute to community life. Mental health describes the capacity of individuals and groups to interact, inclusively and equitably, with one another and with their environment in ways that promote subjective wellbeing, and optimise opportunities for development and the use of mental abilities. Mental health is not simply the absence of mental

⁴⁵ Dianne Hales and Robert E Hales, *Caring for the Mind: The Comprehensive Guide to Mental Health* (Bantam Books, 1995) 34. Myers *et al* devised a wellness model to promote healthy functioning. It has at its centre five life tasks - essence or spirituality, work and leisure, friendship, love and self-direction and 12 sub tasks - sense of worth, sense of control, realistic beliefs, emotional awareness and coping, problem solving and creativity, sense of humour, nutrition, exercise, self care, stress management, gender identity, and cultural identity. See also J Melvin Witmer and Thomas J Sweeny, ‘A holistic model for wellness and prevention over the lifespan’ (1992) *Journal of Counseling and Development* 140.

⁴⁶ Weare, above n 39, 12.

⁴⁷ Department of Health and Ageing, ‘National Mental Health Plan’ (Plan, Australian Government, April 1992) <[http://www.health.gov.au/internet/main/publishing.nsf/Content/8E185E7F3B574CCFCA2572220005FF0D/\\$File/plan92.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/8E185E7F3B574CCFCA2572220005FF0D/$File/plan92.pdf)>.

⁴⁸ Australian Health Ministers, ‘Second National Mental Health Plan’ (Plan, Commonwealth Department of Health and Family Services, July 1998). <[http://www.health.gov.au/internet/main/publishing.nsf/Content/0284E597D0DD5B95CA257261001083A7/\\$File/plan2.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/0284E597D0DD5B95CA257261001083A7/$File/plan2.pdf)>.

⁴⁹ Ibid 26.

illness. Its measurement is complex and there is no widely accepted measurement approach to date. The strong historical association between the terms ‘mental health’ and ‘mental illness’ has led some to prefer the term ‘emotional and social wellbeing’, which also accords with holistic concepts of mental health held by Aboriginal peoples and Torres Strait Islanders and some other cultural groups, or alternatively, the term ‘mental health and wellbeing’.⁵⁰

It is this definition which highlights a number of the difficulties associated with trying to arrive at a single explanation for the concept of mental health. It acknowledges the ‘strong historical’ connection between the terms ‘mental health’ and ‘mental illness’ but it does not provide any details as to where, and with whom, this association lies. The comment may refer to the public’s recent memory of lunatic asylums⁵¹ as places where strangely different and dangerous people were locked away, sometimes for life, from decent, normal people. Linking the two terms and connecting them with negative associations helps perpetuate stigma.

Rather than trying to define ‘mental health’ for the purpose of clarity and consistency, the government has simply noted a discussion that needs to occur but that to date has been avoided because it is perceived to be too difficult a task. The interchangeability of the established language and the development of new, positive alternative terminology such as ‘emotional and social wellbeing’ do not suggest mental health sector growth and strength but rather, point to a disorganised and confused attempt to distance itself from the stigma associated with mental illness. Defining ‘mental health’ by including disclaimers and preferential alternatives suggests policy analysts are ill-equipped to work within the fluid mental health parameters. The definition concedes that there is no widely accepted measurement approach by which mental health can be measured.

The current Fourth Mental Health Plan inexplicably omitted a definition for mental health from its glossary of terms altogether, which may suggest that it chose to follow the WHO tactic which is that the best way to define mental health is simply

⁵⁰ Australian Health Ministers, ‘National Mental Health Plan 2003-2008’ (Plan, Australian Government, July 2003) 35
<[http://www.health.gov.au/internet/main/publishing.nsf/content/EE630ADE7F40F80FCA2572220002D081/\\$File/plan03.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/EE630ADE7F40F80FCA2572220002D081/$File/plan03.pdf)>.

⁵¹ Royal Derwent Hospital was Australia’s oldest mental asylum operating from 1827. It was only closed in 2000.

to avoid trying to do so. Definitions should not, however, be avoidable in public policy.⁵² They are useful for thought and language.⁵³ Commonly accepted endoxa, they remain acceptable until challenged, moving theories, concepts and practices forward. They are the premises for complex patterns of reasoning, compartmentalising unfamiliar entities into familiar categories.⁵⁴ ‘Definitions are crucial argumentative instruments in law. They support the classification of entities in legal categories, and consequently warrant the enforcement of legal consequences.’⁵⁵ Mental health law is built on the concept of mental health, yet the language of mental health lacks the clarity, precision and consistency that the law requires. Without clarity, precision and consistency, law lacks predictability⁵⁶ and may lead to arbitrary applications of preferential language and differences in conceptualising mental health, impacting detrimentally on people experiencing mental illness.

Although a standardised definition of ‘mental health’ may be contentious, lack clarity, and be misinterpreted, a bigger problem occurs when terms are interchangeable, contradictory, or there is a definitional void altogether. Mental health does not simply confine itself to the provision of medical care but can significantly impact on an individual’s legal right to liberty, bodily integrity, life choices and financial autonomy - all matters for judicial determination. If individual and collective goals consistent with justice⁵⁷ - qualities of fairness, equality, and practical conformity with the law - are to be achieved for people experiencing a mental illness, a clear and consistent understanding of mental health, as a platform for mental health law, needs to be established.

⁵² Paula Braveman, ‘Health Disparities and Health Equity: Concepts and Measurement’ (2006) 27 *Annual Review Of Public Health* 167.

⁵³ Plato (429–347 B.C.) Theory of Forms, A discussion will usually require at some point, an explicit definition of one or more of the general terms on which the discussion hinges. Even if a definition is misdefined, its wrongness can be instructive. See William David Ross, *Plato's Theory of Ideas* (Clarendon Press, 1951).

⁵⁴ Fabrizio Macagno, ‘Definitions in law’ (2010) 2 *Bulletin Suisse de Linguistique Appliquée* 199.

⁵⁵ *Ibid* 215.

⁵⁶ Constantin Stefanou and Helen Xanthaki, *Drafting legislation: A Modern Approach* (Ashgate Publishing, 2008).

⁵⁷ Australian Health Ministers, ‘Second National Mental Health Plan’ (Plan, Commonwealth Department of Health and Family Services, July 1998) 26

<[http://www.health.gov.au/internet/main/publishing.nsf/Content/0284E597D0DD5B95CA257261001083A7/\\$File/plan2.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/0284E597D0DD5B95CA257261001083A7/$File/plan2.pdf)>.

3.2 Mental health problems

Mental health problems are situated within the hierarchical framework of mental health. They are indicative of a policy category of 'not quite a mental illness' when measured against traditional medical diagnoses such as schizophrenia, bipolar and depression.⁵⁸ They have developed as a consequence of medicalisation: the occurrence of human problems or experiences defined as medical problems, usually in terms of illnesses, diseases, or syndromes.⁵⁹ Usually occurring as a result of life stressors, a mental health problem interferes with a person's cognitive, emotional or social abilities, but may not meet the criteria of an illness. A person with a mental health problem may also experience the disadvantages associated with a mental illness including prejudice and discrimination, and authoritative intervention by the state with its imposition of restrictions, and concurrent decrease in permitted decision-making. While potentially subject to the same control measures of the legal system, mental health problems do not attract the same protections. The law in Australia does not recognise discrimination against people who experience mental health problems because 'mental health problems' do not fall within the disease centric definitions of 'mental illness' or 'disability' which is 'a total or partial loss of the person's bodily or mental functions'.⁶⁰

'Mental illness is still not well understood in the community. There is confusion about what it means and how it can be managed.'⁶¹ The addition of 'mental health problems' to the conceptual and language mix of mental health reflects a crossover between what have historically been regarded as separate medical and social issues, causing even more confusion about mental illness. Even for mental health professionals, the distinction between 'mental illness' and 'mental health problem' is complex, and not well understood.⁶² Social problems such as poverty, illiteracy and alcoholism have been medicalised as diseases and people who were previously labelled as socially disadvantaged are now additionally labelled as mentally ill, a

⁵⁸ Howard H Goldman and Gerald N Grob, 'Defining 'Mental Illness' In Mental Health Policy' (2006) 25 *Health Affairs* 737.

⁵⁹ Conrad and Barker, above n 35.

⁶⁰ *Disability Discrimination Act 1992* (Cth) s 4; *Anti-Discrimination Act 1998* (Tas) s 3.

⁶¹ Victoria Legal Aid, *Mental health and your rights* <<http://www.legalaid.vic.gov.au/mentalhealth.htm>>.

⁶² Tricia Szirom, Debbie King and Kathy Desmond, 'Barriers To Service Provision For Young People With Presenting Substance Misuse And Mental Health Problems' (Report, Australian Government Department of Family and Community Services, October 2004).

label that attracts very high levels of negative stereotyping, prejudice and discrimination. This is discussed more fully in Chapter Three.

Theoretically, the person experiencing poor mental health will either have a biomedical mental disorder or a psychosocial mental health problem which is a disorder caused or influenced by life experience and includes alcoholism and aggression (see below at 4.4). Either cause, however, increases the person's vulnerability to stigma: civil, political, and socio-economic disadvantage, and their interaction with the legal system. Mental health problems are classed as significant indicators of poverty, and are generally conceded as both a determinant, and a consequence of social issues including poor mental health,⁶³ homelessness;⁶⁴ unemployment;⁶⁵ poor education;⁶⁶ and increased risk of contact with the criminal justice system.⁶⁷ They cut across racial, ethnic, and socioeconomic lines to affect a large proportion of communities worldwide.⁶⁸

Defining a 'mental health problem' has been an expanding process. Australia's Third Mental Health Plan 2003-2008 defined it as a disruption in the interaction between the individual, the group and the environment which produced a diminished state of mental health.⁶⁹ This definition was very broad. Any situation or circumstance that disrupted the subjective well-being of a person, such as their participation in a personal disagreement, receipt of bad news, or disappointment in failing to realise a particular want had the potential to trigger a mental health problem. While acknowledging the complexity and diversity of views in defining mental illness and mental health disorders, the Plan, frequently used a number of

⁶³ Vijaya Murali and Femi Oyeboade, 'Poverty, social inequality and mental health' (2004) *Advances in Psychiatric Treatment* 216, 217.

⁶⁴ Mental Health Council of Australia, 'Home Truths: Mental Health, Housing and Homelessness in Australia' (Report, Mental Health Council of Australia, March 2009) <<http://www.mhca.org.au/documents/MHCA%20Home%20Truths%20Layout%20%20FINAL.pdf>>.

⁶⁵ Mental Health Council of Australia, 'Let's Get to Work: A National Mental Health Employment Strategy' (Report, Mental Health Council of Australia, November 2007) <<http://www.mhca.org.au/documents/MHCA-Employment%20Report-final.pdf>>.

⁶⁶ Gavin Turrell *et al.*, 'Health Inequalities in Australia: Morbidity, health behaviours, risk factors and health service use' (Report No 2, Queensland University of Technology and the Australian Institute of Health and Welfare, March 2006) 93 <<http://www.aihw.gov.au/publications/phe/hiamhbrfhsu/hiamhbrfhsu.pdf>>.

⁶⁷ Matthew T Theriot and Steven P Segal, 'Involvement with the Criminal Justice System Among New Clients at Outpatient Mental Health Agencies' (2005) 56 *Psychiatric Services* 179, 179. The American study found that 36% of new community patients had at least one criminal conviction with 19% having a felony conviction. "Common charges and convictions included petty theft, assault and battery, felony theft, narcotics offenses, and misdemeanor drug offenses. Clients who had been involved with the criminal justice system were more likely to be homeless, to have drug dependence, to have greater psychological disability, and to have less personal empowerment than other clients."

⁶⁸ Lester Breslow (ed), *Encyclopedia of Public Health* Volume 3, (Gale Cengage, 2002).

⁶⁹ Szirom, King and Desmond, above n 62, 35.

different terms including ‘mental health disorder’, ‘mental health issue’, ‘mental illness’ and ‘mental health problem’, seemingly interchangeably, to describe a number of conditions, exacerbating the existing confusion.

The Fourth Mental Health Plan 2009 - 2014 narrowed the definition by stating that for a person to have a ‘mental health problem’, they had to experience diminished emotional, cognitive or social abilities but not at the level that satisfied the criteria for diagnosing a mental illness.⁷⁰ What this, the current definition has done is expand the parameters of mental health to include a lack of social ability. It has created the impression that a mental health problem is not ‘quite’ a mental illness. It also irrevocably associates social disadvantage with mental illness in the public mind. For example, Phelan *et al.* found that much of the public operates under the assumption that many homeless people are mentally ill and react to them accordingly: ‘in effect they transfer the stigma of mental illness to homeless people’.⁷¹

The existing stigma associated with the poor and homeless is intensified by the coexistence of the ‘mentally ill’ label. Homeless people identified as having a mental disorder represent a substantial proportion of the people incarcerated within the criminal justice system, for example, although the cohort is representative of only a very small proportion of the total population.⁷² This group is also incarcerated for substantially longer periods. This suggests that the prison system is *de facto* assuming responsibility for problems traditionally belonging in the social welfare system, in areas such as public housing.⁷³ Social problems have become erroneously simplified as psychiatric problems, resulting in the creation of overly simple interventions and policies to address a complex phenomenon.⁷⁴

⁷⁰ Ibid 84.

⁷¹ Jo C Phelan *et al.*, ‘The Stigma of Homelessness: The Impact of the Label "Homeless" on Attitudes Toward Poor’ (1997) 60 *Social Psychology Quarterly* 323, 327.

⁷² Dale E McNeil, Renee L Binder and Jo C Robinson, ‘Incarceration Associated With Homelessness, Mental Disorder, and Co-occurring Substance Abuse’ (2005) 56 *Psychiatric Services* 840.

⁷³ Ibid.

⁷⁴ Jeffrey Draine *et al.*, ‘Role of Social Disadvantage in Crime, Joblessness, and Homelessness Among Persons With Serious Mental Illness’ (2002) 53 *Psychiatric Services* 565.

3.3 ‘Mental health’ as recognition of human potential

There has been a recent trend in public health policies to link human potential with mental health, or perhaps more accurately, link the failure to achieve a non-measurable standard of wellbeing and optimal development with poor mental health and psychological disability. WHO’s definition of health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’⁷⁵ positions mental health as an essential dimension integral to attainment of the state of being healthy. Mental health is the reference point: a relative state of mind in which an individual is able to psychologically cope with, and adjust to the recurrent stresses of everyday living in a manner that is socially acceptable.⁷⁶

A mentally healthy person is recognised for their possession of positive characteristics that include a sense of contentment, a zest for living, the ability to laugh and have fun, a good balance between work and leisure, self confidence and high self esteem, and the ability to build and maintain fulfilling relationships that are reflective of emotional, psychological and social well-being.⁷⁷ However, the pressures of modern living have given unprecedented cause for the ordinary person’s inability to meet optimal standards for acceptable social functioning⁷⁸ to the extent that their psychological inability has become both a source, and a measure of mental illness.

People, who in the past would not have presented with symptoms that satisfied the existence of a mental illness, are now being labelled ‘mentally ill’ due to their inability to function at normative standards of social expectations. What has historically been society’s tendency to blame social and moral problems on medical causes has developed into the 21st century’s medicalisation of human life experiences, a phenomenon which is discussed in more detail in Chapter Two. Increasingly, more and more people are coming before the legal system carrying the

⁷⁵ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948.

⁷⁶ Keith Anderson et al (eds), *Mosby's Medical, Nursing and Allied Health Dictionary* (Mosby, 5th ed, 1998).

⁷⁷ William C Compton, *Introduction to Positive Psychology* (Wadsworth, 2005).

⁷⁸ See Chapter 22 ‘Stress’ in Julia Russell and Matt Jarvis, *Angles on Applied Psychology* (Nelson Thornes, 2003).

label of ‘mentally ill’ which can have a detrimental impact on their legal outcomes.⁷⁹

Being mentally healthy is having the capacity to interact with others, inclusively and equitably, and with the environment, in ways that promote satisfactory levels of subjective wellbeing and optimal development.⁸⁰ It entails the person having the use of cognitive, affective and relational abilities.⁸¹ Mental health, defined in this way, requires far more than merely establishing the absence of a mental illness, mental disease, or mental disorder. It requires the realisation of human potential. By normatively conceptualising mental health as a state of cognitive and emotional well-being in which the individual realises his or her own abilities; has the ability to cope with the normal stresses of life; works productively and fruitfully; and is able to make a contribution to his or her community⁸² posits the requirement to self-examine personal attributes and self capabilities to the extent of reaching an understanding of the very nature of what it is to be a human being. But this type of self reflection must occur in a world of changing ideals and values.

By taking a neoliberal approach and creating a definitional anchoring of mental health to human potential, public policy makes the statement that the social worth of an individual is to be measured according to the level of material success, and that peace and happiness are achieved from the value of honest hard work.⁸³ This opinion is not new. In the past, having a good work ethic and possessing skills were personal characteristics likely to ensure stability and longevity in employment. In the current employment climate, economic trend analysis, technological advances, legislative regulations⁸⁴, financial growth indicators and profit margins,

⁷⁹ Susan Henderson, ‘Mental Illness and the Criminal Justice System’ (Review, Mental Health Co-ordinating Council, May 2003) <<http://www.mhcc.org.au/documents/PosPaper%20CrimJustice%20May03.pdf>>. See also National Coalition for the Homeless, ‘Mental Illness and Homelessness’ (Fact Sheet No 5, National Coalition for the Homeless, June 2006) <http://www.nationalhomeless.org/publications/facts/Mental_Illness.pdf>. See also Lisa Handwerker, ‘Medical risk: implicating poor pregnant women’ (1994) 38 *Social Science & Medicine* 665.

⁸⁰ Australian Health Ministers, above n 50, 5.

⁸¹ Commonwealth Department of Health and Aged Care and the Australian Institute of Health and Welfare, ‘National Health Priority Areas Report Mental health: A Report Focusing on Depression’ (Report No PHE 11, Commonwealth Department of Health and Aged Care, Australian Institute of Health and Welfare, 1998) 5.

⁸² Mental Health Promotion Case Studies from Countries, A Joint Publication of the World Federation for Mental Health and the World Health Organization, World Federation for Mental Health (2004) World Health Organization <http://www.who.int/mental_health/evidence/en/case_studies_report.pdf>.

⁸³ A strong and continuing protestant value is that all that is good comes from a man’s hard labour. This point is discussed well in Cynthia Lynn Lyerly’s book *Methodism and the Southern Mind, 1770-1810* (Oxford University Press, 1998).

⁸⁴ ‘One third of workforce sacked at NSW chicken meatworks’, *ABC*, 07/02/2012. ‘A third of the Inghams Chicken says it’s had to cut around a third of its workforce (80) at the Byron Bay site, because it can’t afford to

often factors well beyond the control of both employees and employers are much more likely to influence employment decisions.⁸⁵ It is becoming increasingly difficult for people to realise their full potential in the modern world when there is little predictability to the outcomes of the decisions they make.

The ranks of the poor and disadvantaged on every urban landscape have historically been stereotypically blamed for lacking the personal desire to work gainfully; the discipline necessary to maintain employment; and for failing to possess a proper sense of responsibility.⁸⁶ Causal indicators for unemployment and poverty such as poor education, housing, and health care are largely ignored by the public perception in the stereotypical construction of the disadvantaged as ‘dole bludgers’, ‘free loaders’ and ‘welfare cheats’.⁸⁷

The linking of mental health with the failure to reach human potential not only reinforces the public perception that people who are socially disadvantaged have a biomedical mental illness, it contributes to the creation of a distinct new group of ‘mentally ill’ individuals that includes for example, people who are divorced, have never married, are shy, work a lot, or simply don’t laugh enough. It generates a moralistic perspective that blames and punishes individuals who fail to demonstrate the capacity to cultivate a subjective level of wellbeing, labeling them, ‘mentally unhealthy’. This new label has the potential of substantially increasing the numbers of people finding themselves subjected to the social stigmatisation and marginalisation associated with the personal experience of mental illness. It also increases the likelihood that should they come into contact with the legal system for which the central concern is risk minimisation, they will be discriminated against.⁸⁸ This is evidenced in Chapter Six which examines recent Australian family court

upgrade its waste water facility to meet Environmental Protection Authority standards.’

<<http://www.abc.net.au/rural/news/content/201202/s3424547.htm>>

⁸⁵ Vicor Zarnowitz, ‘Theory and History Behind Business Cycles: Are the 1990s the Onset of a Golden Age?’ (1999) 13 *Journal of Economic Perspectives* 69.

⁸⁶ Judith Goode, ‘How Urban Ethnography Counters Myths about the Poor’ in George Gmelch, Robert V Kemper and Walter P Zenner (eds), *Urban life: readings in the anthropology of the city* (Waveland Press, 2002) 279.

⁸⁷ Tony Eardley and George Matheson, ‘Australian Attitudes to Unemployment and Unemployed People’ (Discussion Paper, No 102, Social Policy Research Centre, June 1999). See also Michael J Dee, ‘Harsh times at the Ministry of Fear? Australia’s diminished citizenship of the working poor’ (Paper presented at Social Change in the 21st Century, Brisbane, 21 November 2003).

⁸⁸ Steve Turner, ‘Risk assessment and management’ in Tim Riding, Caron Swant and Bob Swann (eds), *The Handbook Of Forensic Learning Disabilities* (Radcliffe Publishing, 2005).

decision-making in parenting matters where a parent has, or is perceived to have, a mental illness.

3.4 Poor mental health

The commitment of western societies to reason as a primary value⁸⁹ sets the design and constraints of what is acceptable human behaviour. Any impediment perceived to cause a decrease in a person's ability to rationalise is considered to negatively impact on their actions and behaviour thereby causing social dysfunction. The value of social performance is another element by which a person can be judged as socially dysfunctional and consequently, as experiencing mental health problems; a psychiatric disability; or diagnosed as suffering from a mental illness. Ascribing poor mental health to an individual is a societal response to poor social functioning.⁹⁰

The level of personal happiness and satisfaction is usually judged against the measure of performance in careers and relationships⁹¹ and when evaluating happiness and self satisfaction, there is a tendency to apply disproportionate weight to income and health as the primary indicators of wellbeing.⁹² A recent global study of more than 150 countries identified the five essential elements of wellbeing that differentiate a thriving life from one spent suffering as - career, social, financial, physical, and community engagement.⁹³ The results suggested that 66% of the population are achieving optimal results in at least one of the essential element areas while only 7% thrive in all five.⁹⁴

The reason for this low result may be explained in part by the fact that often the factors leading to the emotional outcomes of wellbeing are beyond a person's control. For example, having a genetic disease will not be cured through hard work

⁸⁹ Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (Vintage Books, 1988). In this, his first book, Foucault examines the ideas, practices, institutions, art and literature relating to madness in Western history. In it he argues that the gradual disappearance of leprosy left a void which was filled by madness. In the 17th century, a movement which Foucault called the Great Confinement redirected the physical and social exclusion of lepers toward the mad who were locked away and institutionalized. By the 18th century, the mad were treated as animal-like. They had lost the essential element that separated humans from beasts: their reason.

⁹⁰ Lynne Friedli, 'Mental health, resilience and inequalities' (Report, World Health Organization, 2009).

⁹¹ Sharon Jeffcoat Bartley, William Judge and Sharon Judge, 'Antecedents of Marital Happiness and Career Satisfaction: An Empirical Study of Dual-Career Managers' (2007) 1 *Journal of Business and Public Affairs* <<http://www.scientificjournals.org/journals2007/articles/1059.htm>>.

⁹² Tom Rath and James K Harter, *Wellbeing: The Five Essential Elements* (Gallup Press, 2010).

⁹³ Ibid.

⁹⁴ Ibid.

and commitment, and having a strong work ethic will not alter the likelihood that the blue collar worker made redundant at age 56 will find it difficult to find new full-time employment quickly, if at all. Feeling unhappy or discontented, or simply existing in apathy, and feeling neither, can be consequences of personal impotence, and inadequacy in completing the tasks of life necessary to achieve expected ideals. This combination of powerlessness and sense of inadequacy is a cause of the rising rates for depression,^{95 96} the emblematic malaise of our time,⁹⁷ and which is particularly evident in the relationship matters dealt with within the family law system in those matters in which mental illness is a factor, a topic discussed in Chapter Six.

Poor mental health has become a major public health concern because of the adverse effects it has on functioning, economic productivity, capacity for healthy relationships and families, physical health, and overall quality of life.⁹⁸ The emerging discipline of mental health promotion is proactively charged with preventing mental health problems from occurring rather than reactively providing treatment related services after the event.⁹⁹ This policy pinpoints a person's mental health and wellbeing as lying within their social and economic domains. Consequently, mental health promotion addresses the determinants to mental health and wellbeing such as social inclusion, having a valued social position, physical and psychological security, opportunities for self determination and control over life, and access to meaningful employment, education, income and housing.¹⁰⁰

Mental health problems are viewed as the antithesis of mental well-being, and maintaining a state of good mental health is a fundamental goal. An assessment of a person's mental health as good is the measure used to judge that the person has the

⁹⁵ 1 in 5 Australians will experience depression at some point in their lifetime: around one million adults and 100,000 young people live with depression each year; depression is currently the leading cause of non-fatal disability in Australia, but only 3 per cent of the population identifies it as a major health problem; over six million working days are lost each year in Australia as a result of depression; depression costs the Australian community over \$600 million each year; beyondblue <<http://www.beyondblue.org.au/>>.

⁹⁶ Kelly G Lambert, 'Rising rates of depression in today's society: Consideration of the roles of effort-based rewards and enhanced resilience in day-to-day functioning' (2006) 30 *Neuroscience and Biobehavioral Reviews* 497.

⁹⁷ Zygmunt Bauman, *The Individualized Society* (Polity Press, 2001) 42.

⁹⁸ Breslow, above n 68.

⁹⁹ Helen Keleher and Rebecca Armstrong, 'Evidence-based mental health promotion resource' (Report, Victorian Government Department of Human Services, 2006)

<http://www.health.vic.gov.au/healthpromotion/downloads/mental_health_resource.pdf>.

¹⁰⁰ Friedli, above n 90. See also Helen Keleher and Rebecca Armstrong, 'Evidence-based mental health promotion resource' (Report, Victorian Government Department of Human Services, 2006) <http://www.health.vic.gov.au/healthpromotion/downloads/mental_health_resource.pdf>.

psychological resilience to adapt to the full range of life's demands and the ability to manage the traumas, stresses and disappointments of living.¹⁰¹ The capacity to cope is a valued and idealised objective of a functionalist society because it guarantees that normalcy is maintained. The problem is that it is becoming increasingly more difficult for mentally healthy people to cope in their daily lives. Factors such as the mounting financial stress on families¹⁰² and employment uncertainty¹⁰³ contribute to relationship breakdowns which increase a person's potential to develop mental health problems. This may then be exacerbated by a legal system that is inherently prejudiced toward people experiencing mental problems.

4. THE SOCIAL MODEL APPROACH TO MENTAL HEALTH POLICIES

The social model approach to mental health relates to a psychological concept to explain that mental health is affected by social causes such as negative attitudes and social exclusion and focuses on educating people and enabling them to regain control of their lives. Increasingly, the social model approach is being adopted as the ideological and pragmatic framework for Australian mental health policies. However, despite the strong support given to applying this approach to mental health policies by addressing the interrelationship of mental distress and the problems of everyday life to mental health, it has not resulted in the creation of a single, coherent, social model.¹⁰⁴ There is a lack of clarity as to what the social approach means in mental health practice and it has not had any significant influence on current biomedical thinking and practice.¹⁰⁵ The model is too loosely defined and its language is open to different interpretations. Its implementation is *ad hoc* and fails to adequately address the status and needs of people experiencing mental illness which differ from people in the disability sector. The impairment ideology of the model is incongruous to mental health because 'impairment' cannot

¹⁰¹ Friedli, above n 90.

¹⁰² Arthur Karabatos, Andrew Gill and Andrew Crawshaw-Fardouly, 'Australian Mortgage Delinquencies by Postcode' (Report, Moody's Investor Service, 28 September 2011) <<http://www.scribd.com/doc/66629751/Report-Aussie-Mortgage-Delinquencies-by-Postcode-Sep2011>>.

¹⁰³ Janet Mantler *et al.*, 'Coping with employment uncertainty: a comparison of employed and unemployed workers' (2005) 10 *Journal of Occupational Health Psychology* 200.

¹⁰⁴ Tew, above n 2, 9.

¹⁰⁵ Ibid 14.

be understood as a fixed structural or mechanical abnormality, not in the same way that deafness, blindness, or paralysis can.

Historically, public health policies were founded on an acceptance of the biomedical perception of normalcy, and the narrow band of legitimate, scientific knowledge and practices that rested in the medical profession.¹⁰⁶ The ‘problem’ was with the diseased person, and public health policies responded with a medical/individualistic approach of service delivery: treatment, hospital care, and community supports to cure, or alleviate the effects of the disease.¹⁰⁷ The social model on the other hand, locates the ‘problem’ within society, a view that represented an ideological reversal of the internal to the external. It is a conceptual framework in which improvements in health and wellbeing are made by addressing the social and environmental determinants of health, in combination with biological and medical factors.¹⁰⁸ The public policy adoption of the social model of health, with its departure from the biomedical model of disease, marked a changeover from ‘old public health’ to ‘new public health’.¹⁰⁹

The social model emerged from the publication of *The Fundamental Principles of Disability*¹¹⁰ in 1976,¹¹¹ quickly gaining academic credibility¹¹² and widespread favour with the disability sector.¹¹³ It is currently the dominant model for researching disability.¹¹⁴ The social model was a reaction, and an alternative, to the traditional biomedical paradigm that regards the person and their symptoms as the sole focus of intervention. The person-centric biomedical model sets the disease, disorder, and illness at the immutable heart of the social problems being

¹⁰⁶ Kate Seelman, ‘Trends in rehabilitation and disability: transition from a medical model to an integrative model’ (2004) 22 *Disability World* <www.disabilityworld.org/01-03_04/access/rehabtrends1.shtml>.

¹⁰⁷ Glenn Roberts and Paul Wolfson, ‘The rediscovery of recovery: open to all’ (2004) 10 *Advances in Psychiatric Treatment* 37.

¹⁰⁸ Department of Human Services, ‘Community health counselling: Policy framework and program standards’ (Policy framework, Victorian Government Department, February 2009) 66.

¹⁰⁹ Maria Joyce, ‘From past to present; the changing focus of public health’ (MSc dissertation, University of Lincoln, unpublished) <http://eprints.lincoln.ac.uk/1839/3/Public_health_paper.pdf>.

¹¹⁰ ‘Fundamental Principles of Disability’, The Union of the Physically Impaired Against Segregation and the Disability Alliance, A summary of the discussion held on 22nd November, 1975, <<http://disability-studies.leeds.ac.uk/files/library/UPIAS-fundamental-principles.pdf>>

¹¹¹ Colin Barnes and Mike Oliver, ‘Disability: A Sociological Phenomenon Ignored by Sociologists’ (Research Paper, June 1993) <<http://www.leeds.ac.uk/disability-studies/archiveuk/Barnes/soc%20phenomenon.pdf>>.

¹¹² Victor Finkelstein, *Attitudes and disabled people* (World Rehabilitation Fund, 1980). Also Michael Oliver, *The politics of disablement* (Macmillan, 1990). Also Michael Oliver, *Understanding disability: from theory to practice* (Macmillan, 1996).

¹¹³ Disability Council of NSW (Disability Council), *A Question of Justice: Access to Participation for People with Disabilities in Contact with the Justice System*, Disability Council, Sydney, 2003, p. 19

¹¹⁴ Guy Dewsbury *et al.*, ‘The anti-social model of disability’ (2004) 19 *Disability & Society* 145.

experienced and advocates changing the individual by curing them, or alleviating their pain and suffering. The social model, on the other hand, seeks to change society and the ways in which it responds to the person's needs and interests.¹¹⁵

The social model emphasises society's responsibility to effect positive changes in the well-being and prosperity of impaired individuals and their communities. The 'disability' is perceived as a function of 'society's failure to provide appropriate services and adequately ensure the needs of disabled people are fully taken into account in its social organisation'.¹¹⁶ It imposes a social obligation to ameliorate services and displace social and economic barriers, exclusions and discriminations, the historical sources of disability. In mental health, however, the sources of mental illness are innate or acquired genetic or biological factors that render a person vulnerable to psychosocial and environmental factors, and it is this vulnerability, working in unison with structural environmental forces that can manifest in the unacceptable behaviours of a person who is experiencing a mental illness.¹¹⁷

Now well ensconced within the disability sector, the social model is perceived as a dynamic, conceptual framework for coherent and effective collective action.¹¹⁸

Although the social model does not have a set of rules that define it, only loose definitions characterised by certain attributes such as a lack of functioning,¹¹⁹ it underpins a commitment to civil and human rights, self-organisation, independent living, social inclusion and anti-discrimination and has become the ideological litmus test for progressive policies and laws.¹²⁰ The shift away from internal disablement based on an individual's impairment to external disablement resulting from the social system's failure to enable the person means that any fault or blame rests with society, and not with the individual. In this way, it is viewed as an apparatus for the dismantling of stigma. The achievement of the disability

¹¹⁵ Tom Shakespeare and Nicholas Watson, 'The social model of disability: an outdated ideology?' (2002) 2 *Research in Social Science and Disability* 9.

¹¹⁶ Michael Oliver, *Understanding Disability From Theory to Practice* (MacMillan Press, 1996) 32.

¹¹⁷ Jonathan Kenneth Burns, 'Mental Health and Inequity: A Human Rights Approach to Inequality, Discrimination, and Mental Disability' (2009) 11 *Health and Human Rights* 19.

¹¹⁸ Peter Beresford and Jan Wallcraft, 'Psychiatric System Survivors and Emancipatory Research: Issues, overlaps and differences' in Colin Barnes and Geof Mercer (eds), *Doing Disability Research* (The Disability Press, 1997) 66.

¹¹⁹ International Classification of Functioning, Disability and Health (ICF), The ICF was officially endorsed by all 191 WHO Member States in the Fifty-fourth World Health Assembly on 22 May 2001 (resolution WHA 54.21)

¹²⁰ Shakespeare and Watson, above n 115.

movement has been to break the link between our bodies and our social situation, and to focus on the real cause of disability, i.e. discrimination and prejudice.¹²¹

4.1 Mental illness and the social model – a problematic fit

Laws are an important tool in any attempt to reduce social exclusion and improve well-being because they can remove barriers.¹²² Interpreting a ‘barrier free environment’ however has generated a policy focus on mobility impairment and accessibility in areas such as transport, buildings and communication.¹²³ For example, the Tasmanian government in 2011 advised that discussions were underway at a national level to develop a Premises Standard under the *Disability Discrimination Act 1992* (Cth) to improve transparency and predictability in relation to legislative requirements for providing access to new buildings and/or existing buildings being renovated or extended, and to improve the current level of compliance with the Act.¹²⁴ However, for people experiencing mental illness, ‘you could try to remove as many barriers as possible but pain, hearing voices and feeling the need to self harm may still exist’.¹²⁵ Mental illness may be as equally disabling for each individual but the experiences may be vastly different. Mental illness does not sit easily within the disability social model approach taken by policy-makers.

Mental illness is an impairment that is not easily seen. It is a condition that may not be permanent. It is also episodic in that significant disruption to normal functioning will commonly occur in peaks and valleys throughout a person’s life, and the frequency and severity of dysfunctional episodes is different for each person.¹²⁶ This indicates a level of inconsistency in individual service needs that is not so apparent in the disability sector. Impairment generally for the ‘disabled’ person is

¹²¹ Tom Shakespeare, ‘A Response to Liz Crow’ (1992) *Coalition* 40.

¹²² Roger Mackett, Kamalasudhan Achuthan and Helena Titheridge, ‘Reducing social exclusion by removing the barriers to everyday physical activity’ (Presentation at the 2nd International Congress on Physical Activity and Public Health, Amsterdam, The Netherlands, 13-16 April 2008).

¹²³ Ministry of Social Affairs, ‘Accessibility for the Disabled - A Design Manual for a Barrier Free Environment’ (Manual, United Nations, 2003) <<http://www.un.org/esa/socdev/enable/designm/>>.

¹²⁴ Department of Premier and Cabinet, ‘Disability Action Framework for Action 2013-2017 – A Tasmanian Government plan for people with disability’ (Framework, Tasmania Government, December 2012) <http://www.dpac.tas.gov.au/divisions/cdd/policy/our_policies/disability_framework_for_action/4>.

¹²⁵ Greater London Action on Disability (GLAD), ‘Reclaiming the Social Model of Disability’ (Conference Report, GLAD, 2000) 7 <<http://www.leeds.ac.uk/disability-studies/archiveuk/GLAD/Social%20Model%20of%20Disability%20Conference%20Report.pdf>>.

¹²⁶ Vera A Morgan, ‘People living with psychotic illness 2010: Report on the second Australian national survey of psychotic illness’ (Report, Department of Health and Aging Australian Government, November 2011) <<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-p-psych10>>.

often permanent, and largely unalterable. In contrast, the common expectation of mental impairment is that it manifests in episodes of temporary behavioural aberrance which are medically treatable and controlled.

Where the social model in disability presents the ‘problem’ as external, and beyond individual responsibility, in mental health, responsibility is laid squarely with the person experiencing the mental illness. It is they who must make internal changes through engaging with treatment, and if they do not, they are blamed, and potentially liable to legal compulsion. So, for example, parents experiencing a mental illness who appear in parenting matters before the Family Court, are expected to change how they parent and how they interact in their relationships with their children to an appropriate standard of ‘meaningfulness’, a standard discussed in Chapter Six.

The people who experience a mental illness do not necessarily consider themselves as being disabled because they associate disability with the medicalisation of their distress.¹²⁷ They may demonstrate anxiety about being associated with the negatives linked to the disabled group which is true in reverse, in that people with a disability hold the same stereotypes and fears associated with mental illness as do the wider public. ‘[T]here is a lot of ‘sanism’ in the disability movement.’¹²⁸ Mental illness as a disability is questionable when disability implies a long term unchangeable condition.¹²⁹

The differences between disability and mental health are quite hard to negotiate. A lot of people with mental illness don’t see themselves as disabled and don’t see the advantage of campaigning on joint things around discrimination. Disability organisations don’t always get mental health and don’t want to be seen as mentally defective.¹³⁰

¹²⁷ Beresford and Wallcraft, above n 118.

¹²⁸ Anglicare Tasmania and Tasmanian Mental Health Consumer Network, ‘Experts by Experience: Strengthening the mental health consumer voice in Tasmania’ (Research Paper, Anglicare Tasmania, 2009) 30 <http://www.sswahs.nsw.gov.au/mhealth/content/pdf/Experts_by_Experience.pdf>.

¹²⁹ Ibid. See also Peter Beresford and Jan Wallcraft, ‘Psychiatric System Survivors and Emancipatory Research: Issues, overlaps and differences’ in Colin Barnes and Geof Mercer (eds), *Doing Disability Research* (The Disability Press, 1997).

¹³⁰ Anglicare Tasmania and Tasmanian Mental Health Consumer Network, above n 128.

The social model approach has been considered as helpful at a systemic level where a Marxist focus on social oppression and discrimination¹³¹ brought the issue of prejudice and discrimination to the fore of public policy. On a personal level, many people interpret their mental illness ‘in terms of different understanding, experience or perceptions, rather than as an impairment.’¹³² Although labelled ‘disabled’, they generally view themselves as ill, or experiencing distress at certain times during their life, that impact temporarily on their proper functioning in society.¹³³ They may acknowledge having difficulties but not having a disability.¹³⁴ Although the social model of disability does not appear to represent the needs and interests of people experiencing a mental illness particularly well, its focus on social inclusiveness has brought it many supporters.¹³⁵ Social relationships and social supports are viewed as extremely important for good mental health, the promotion of recovery, and for decreasing the chance of relapse.¹³⁶ But the social model does not seamlessly overlay the different experiences of people with a mental illness.¹³⁷

Interpreting a practical implementation of the model in the disability sector has resulted in a concentration on the issues that impact on a person’s daily life such as accessibility issues, housing, safety from violence, and welfare payments.¹³⁸ While these essential needs and rights have equal importance for the well-being of all people experiencing disadvantage and vulnerability, the social model’s crossover from disability into mental health policy has contributed to the existing confusions and contradictions in the area of mental health without providing a substantive impact on mental health practice, or the legal system. The law still perpetuates the traditional view of disability as something inherent in the person rather than the social construct that is discussed below.

¹³¹ Mike Oliver, ‘Social policy and disability: some theoretical issues’ (1986) 1 *Disability, Handicap and Society* 5. See also Paul Abberly, ‘The Concept of Oppression and the Development of a Social Theory of Disability’ (1987) 2 *Disability, Handicap and Society* 5. Also Deborah Marks, *Disability: controversial debates and psychosocial perspectives* (Routledge, 1999).

¹³² Beresford and Wallcraft, above n 118, 66.

¹³³ Ibid.

¹³⁴ Australian Government, JobAccess - help and workplace solutions for the employment of people with disability,

<http://jobaccess.gov.au/ServiceProviders/Assisting_job_seekers/Supporting_jobseekers_with_different_types_of_disability/What_is_disability/Pages/Understanding_winder_deba.aspx>.

¹³⁵ Beresford and Wallcraft, above n 118, 66. See also Debra Rickwood, ‘Pathways of Recovery: Preventing further episodes of mental illness (monograph)’ (Monograph, Commonwealth of Australia, 2006).

¹³⁶ David J Pevalin and David P Goldberg, ‘Social precursors to onset and recovery from episodes of common mental illness’ (2003) 33 *Psychological Medicine* 299.

¹³⁷ Beresford and Wallcraft, above n 118, 66.

¹³⁸ Tew, above n 2, 9.

4.2 Defining disability

Compounding the conceptual and definitional confusion in mental health is the fact that there is also no single definition of ‘disability’ either.¹³⁹ In Australia, definitions and meanings can vary between Commonwealth and state policy and legislation, and even between agencies within jurisdictions, according to the context and purpose. In the policy context, the development of WHO’s International Classification of Functioning Disability and Health¹⁴⁰ in 2001 shifted the focus of disability from cause to impact which is reflected in the policy definitions of ‘disability’ that are broad, and socially inclusive. In contrast, in operational areas that provide services and financial benefits, definitions are generally much narrower and more exclusive, and are usually based on specific measures of impairment and/or incapacity.¹⁴¹

The *Disability Services Act* 2011 provides the legislative basis for disability services provision in Tasmania. The Act serves to define ‘disability’ and to set down the eligibility criteria for services. The Act states that a person who has a cognitive, intellectual, psychiatric, sensory or physical impairment¹⁴² that is permanent or likely to be permanent,¹⁴³ although it may or may not be of a chronic nature¹⁴⁴ that results in a substantial restriction in their capacity to carry on a profession, business or occupation, or to participate in social or cultural life,¹⁴⁵ and who has a need for continuing significant support services¹⁴⁶ is person who has a disability and is eligible under the Act. However, in recent years, Tasmania has suffered from funding growth well below the already insufficient national average with 454 Tasmanians in need of continuing significant support services reported to be waiting for services in 2008, many of whom had been waiting for two or three

¹³⁹ Michell E Loeb, Arne H Eide and Daniel Mont, ‘Approaching the measurement of disability prevalence: The case of Zambia’ (2008) 2 *ALTER, Revue Européenne De Recherche Sur Le Handicap* 32.

¹⁴⁰ World Health Organisation, ‘Towards a common language for Functioning Disability and Health ICF’ (Report, WHO, 2002).

¹⁴¹ Literature Review For Captivate: Local Participation for All: A Project Funded By Disability Services Commission Department of Sport and Recreation, February 2007 <
http://www.walga.asn.au/Documents/Walga/MemberResources/1623_CAPTIVATE%20Literature%20Review.pdf>

¹⁴² *Disability Services Act* 2011 (Tas) s 4 (a)

¹⁴³ *Ibid* s 4 (b).

¹⁴⁴ *Ibid* s 4 (d).

¹⁴⁵ *Ibid* s 4 (c) (i).

¹⁴⁶ *Ibid* s 4 (c) (ii).

years.¹⁴⁷ Nationally, fewer than 50 out of every 1000 people with severe disabilities receive funded support for the most basic of tasks such as showering, dressing and toileting.¹⁴⁸

The *Disability Discrimination Act* 1992 (Cth) defines disability broadly to include total or partial loss to mental function; and a disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgment or that results in disturbed behaviour.¹⁴⁹ The Tasmanian *Anti-Discrimination Act* 1998 reproduces the Commonwealth's definition but extends the application of the criteria to a disability that 'presently exists, previously existed but no longer exists, may exist in the future, whether or not arising from an illness, disease or injury or from a condition subsisting at birth'.¹⁵⁰ The *Guardianship and Administration Act* 1995 (Tas) describes disability as 'any restriction or lack (resulting from any absence, loss or abnormality of mental, psychological, physiological or anatomical structure or function) of ability to perform an activity in a normal manner'.¹⁵¹

In contrast to the more expansive rights and protections legislative approach to disability, specific disability operational legislation, most likely as a cost minimising exercise, commonly restricts the definition of disability to a situation that is 'permanent or likely to be permanent'.¹⁵²

Those aged over 65, those with psychiatric problems, substance abuse disorders, behaviour disorders (like ADHD or social and emotional problems), those in post acute care and those with chronic medical conditions are excluded unless there is a permanent disabling condition and they are unable to benefit from medical services. Disability Services are not geared to temporary conditions. These are considered to be medical issues which should be dealt with by health services...the bulk of the clientele are 'traditionally' people with intellectual disability (46%). Those with a physical disability

¹⁴⁷ Advocacy Tasmania Inc., Submission to *National Disability Strategy*, November 2008, 5
<http://www.advocacytasmania.org.au/publications/ATI_national_disability_strategy_submission.pdf>.

¹⁴⁸ Dr Ken Baker, *National Disability Services*, *Link Disability Magazine*
<<http://www.linkonline.com.au/Link/article/169>>

¹⁴⁹ *Disability Discrimination Act* 1992 (Cth) s 4.

¹⁵⁰ *Anti-Discrimination Act* 1998 (Tas) s 3.

¹⁵¹ *Guardianship and Administration Act* 1995 (Tas) s 3.

¹⁵² *Disability Services Act* 1992 (Tas) s 3; *Disability Services Act* 1986 (Cth).

form 16% of the clientele and only 7% have acquired brain injury and 8% neurological disabilities and progressive conditions.¹⁵³

Most mental illnesses, are not permanent, are episodic, and are treatable although the impact of the illness on a person's life can be extremely severe, and their need for services necessary. Commonly, mental illness is seen as a low priority in the allocation of limited funds and services because it is largely an invisible disability competing against the strong advocacy of the family and friends of the people experiencing the more permanent and visible, physical, intellectual and cognitive disabilities. The jockeying of large and influential disability groups in competition for funding and furthering the interests of their members has succeeded in emphasising the differences between disability groups rather than the commonalities¹⁵⁴ to the extent that people with psychiatric disabilities are arguably doubly marginalised in that they are unwelcome in both the non-disabled and the disabled communities.¹⁵⁵

4.3 Psychiatric disability

Mental illness is a medical term used to describe the psychological and behavioural patterns associated with the distress experienced by a person who has a diagnosed, or an undiagnosed, mental disorder or disorders. The impact that the mental illness has on a person's functioning in different aspects of their life is defined as a 'psychiatric disability'. Australia's current definition of 'psychiatric disability' is taken from the Fourth National Mental Health Plan 2009-2014 and focuses on a person's ability, or semantically more accurately, their inability to maintain societal norms.

The person experiencing the mental illness is only considered to have a psychiatric disability when their ability to 'live independently, maintain friendships, maintain employment and to participate meaningfully in the community' is diminished.¹⁵⁶

¹⁵³ Teresa Hinton, 'My Life as a Budget Item: Disability, budget priorities and poverty in Tasmania, Anglicare Tasmania' (Research Report, Anglicare, October 2006) 27. <http://www.anglicare-tas.org.au/docs/research/My_Life_as_a_Budget_Item_-_Disability_budget_priorities_and_poverty_in_Tasmania.pdf>.

¹⁵⁴ Ibid.

¹⁵⁵ Sue E Estroff *et al.*, 'Pathways to Disability Income among Persons with Severe, Persistent Psychiatric Disorders' (1997) 75 *The Milbank Quarterly* 495.

¹⁵⁶ Commonwealth of Australia, Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009 – 2014' (Report, Australian Government, 2009) 85.

This definition of ‘psychiatric disability’ does not view having a mental illness as equivalent to having a disability or functional impairment. It presupposes that not everyone who has a mental illness will have their level of functioning decreased to the extent that it satisfies the criteria necessary to meet the definition of ‘psychiatric disability’. This suggests that even though a person may be diagnosed with a major depressive disorder for example, he or she will not be considered as psychiatrically disabled if they still live independently, maintain relationships, and have a job. But at what point is a person’s ability sufficiently diminished to determine that they have a psychiatric disability and who decides what measure of community participation, for example, is necessary to satisfy ‘meaningful’? Is walking to the shops to buy cigarettes once a day sufficient or will the person need to join a club, play a sport, or visit with neighbours?

Over the years, the Commonwealth has developed a number of national mental health policies. The measure of ‘meaningful participation’ was first included in the National Mental Health Policy 2008,¹⁵⁷ defined as the:

capacity of a person to engage in personal, educational, employment, social, political and other activities within their community in such a way that they are able to fully realise their potential and to feel socially valued and personally validated.

This definition was replicated in the Fourth National Mental Health Draft Plan 2009-2014¹⁵⁸ but was left out of the final document. A reason for the omission might be recognition of the difficulties associated with developing a process that would consistently and fairly assess ‘meaningful participation’. If the definition is presented from a systems perspective then the removal of barriers to ensure a person’s meaningful participation in their community is a worthwhile aim, but the definition is person-centric. The person must possess the capacity to engage in ‘such a way’ that internally, they can feel valued and validated although how this sense of value and validation can be measured has not been made known. Chapter

¹⁵⁷ Commonwealth of Australia, ‘National Mental Health Policy 2008’ (Policy Report, Commonwealth of Australia, 2009) 29

<[http://www.health.gov.au/internet/main/publishing.nsf/Content/532CBE92A8323E03CA25756E001203BF/\\$File/finpol08.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/532CBE92A8323E03CA25756E001203BF/$File/finpol08.pdf)>.

¹⁵⁸ Commonwealth of Australia, above n 156, 64.

Six will show that this same problem exists in family law which statutorily binds parents to have ‘meaningful’ relationships with their children.

Although ‘the product of twelve months of development work’¹⁵⁹, the person-centric Plan appears to be in contravention of the Convention on the Rights of Persons with Disabilities¹⁶⁰ which Australia ratified 17 July, 2008. This seems to be another indicator of the inconsistencies and conflicts that exist in mental health. The definition of ‘psychiatric disability’ included in the Plan appears to be in conflict with the social model definition of disability in the Convention which states ‘that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others’.¹⁶¹ The Convention also states that ineffective, non-meaningful community participation is in fact a consequence of external factors: that psychiatric disability isn’t caused from within but by the barriers that are imposed without.

4.4 Psychosocial disability

Newly arriving into the conceptual and definitional mix is ‘psychosocial disability’ which is referenced, although left undefined, in the Commonwealth’s National Disability Strategy 2010-2020. The term, to date, is not widely used although it is favoured as the ‘disability’ definition of the Australian consumer and carer movement.¹⁶² The focus of ‘psychosocial disability’ is social support. Critics argue that it is inappropriate for the health system to provide social support for people with physical disabilities or intellectual disabilities, so it should be so for psychosocial disability.¹⁶³

A psychosocial disability is the result of the ‘complex interactions between limitations in activity (related to impairments associated with usually severe mental

¹⁵⁹ Department of Health and Aging, Publications Page,
<<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-f-plan09>>

¹⁶⁰ Australia ratified the United Nation Convention on 17 July 2008.

¹⁶¹ Convention on the Rights of Persons with Disabilities, Preamble (e)
<<http://www.un.org/disabilities/convention/conventionfull.shtml>>

¹⁶² National Mental Health Consumer & Carer Forum, ‘Unravelling Psychosocial Disability: A Position Statement by the National Mental Health Consumer & Carer Forum on Psychosocial Disability Associated with Mental Health Conditions’ (Forum, National Mental Health Consumer & Carer Forum, 2011)

¹⁶³ Mental Health Carers Arafmi Australia, Submission to Productivity Commission Disability Care and Support, April 2011.
<http://www.arafmiaustralia.asn.au/uploads/7/2/8/9/7289235/mhcaa_submission_to_productivity_commission_-_april_2011.pdf>.

health conditions) and the environment in which people live.’¹⁶⁴ The World Health Organisation’s International Classification of Functioning Disability and Health¹⁶⁵ drew from the biopsychosocial model to describe ‘psychosocial disability’ as a complex phenomenon that reflects the interaction between the features of a person’s body and the features of the society in which the person lives. The model proposes that the community acknowledges its responsibility to provide the resources and supports necessary to assist people with disabilities to participate as equal and valued citizens.¹⁶⁶

Adding to the definitional and conceptual confusions in mental health, this new understanding of ‘psychosocial’ is in conflict with the established biomedical definition which is:

... the psychological and social factors that influence mental health. Social influences such as peer pressure, parental support, cultural and religious background, socioeconomic status, and interpersonal relationships all help to shape personality and influence psychological makeup. Individuals with psychosocial disorders frequently have difficulty functioning in social situations and may have problems effectively communicating with others.¹⁶⁷

A psychosocial disorder is defined as a mental illness caused or influenced by life experiences, as well as maladjusted cognitive and behavioural processes.¹⁶⁸ Alcohol abuse and domestic violence are considered to be signs of psychosocial dysfunction in men for example.¹⁶⁹ The medical model focuses on the psychosocial causes of the person’s ‘problem’ while the social model focuses on the present and future support needs of the person who has a mental condition. ‘Psychosocial disability can exacerbate mental health conditions, cause social isolation and economic marginalisation that can spiral into crisis, homelessness, poverty and risk of harm through exploitation.’¹⁷⁰

¹⁶⁴ Ibid 160, 9.

¹⁶⁵ World Health Organisation, ‘Towards a common language for Functioning Disability and Health ICF’ (Report, WHO, 2002).

¹⁶⁶ World Health Organisation, *Health topics: Disabilities* <<http://www.who.int/topics/disabilities/en/>>.

¹⁶⁷ Farlex, *Psychosocial Disorders* <<http://medicaldictionary.thefreedictionary.com/Psychosocial+Disorders>>.

¹⁶⁸ Ibid.

¹⁶⁹ Ted D Epperly, Kevin E Moore, ‘Health Issues in Men: Part II. Common Psychosocial Disorders’ (2000) 62 *American Family Physician* 117.

¹⁷⁰ National Mental Health Consumer & Carer Forum, above n 162, 9.

The Psychosocial Disability Position Statement of the Association of Relatives and Friends of the Mentally Ill (ARAFMI), the peak body in Australia for carers of people experiencing mental illness states that ‘psychosocial disability, often referred to as psychiatric disability, marks a significant shift in the attitudes of policy makers and the community.’¹⁷¹ This is a good example of the interchangeable use of concepts and language in mental health. Until there are at least clear and consistent messages coming from mental health policies, the confusion being generated will continue to help to fuel the stigma that the policies for the most part are trying to eradicate.

5. CONCLUSION

To date, mental health policy has failed to provide an effective guiding platform for encouraging constructive changes in how the legal system might deal with mental illness. It is a policy area that, although having largely moved away from the biomedical platform, has yet to develop a universally accepted clear, precise and ideologically appropriate mental health model that can effectively guide service practice. Although a significant body of mental health policies has been produced in recent decades, it has developed within different jurisdictional silos. There has been inconsistent referencing of various conceptual models, and a vocabulary of vague and interchangeable terms has been created, all of which has contributed to an uncertain understanding of what ‘mental health’ is, as distinct to what the public understands mental illness to be.

Mental illness evokes a level of fear and avoidance in the public mind that public policy changes have so far failed to diminish because not only are the public’s attitudes rooted in fear, but they are also a reflection of the social disapproval of the communities that mental illness disproportionately affects such as the poor, the homeless and prisoners. Treatment, hospitalisation and legal controls are the mechanisms on which society relies to palliate its ‘fear and loathing’¹⁷² of people who experience mental illness. To prevent or minimise the negative effects of the

¹⁷¹ ARAFMI Australia, *Psychosocial Disability – Position Statement* (24 November 2011) Arafmi Mental Health Carers Australia <<http://www.arafmiaustralia.asn.au/1/post/2011/11/psychosocial-disability-position-statement.html>>.

¹⁷² Jack K Martin, Bernice A Pescosolido and Steven A Tuch, ‘Of Fear and Loathing: The Role of ‘Disturbing Behavior,’ Labels, and Causal Attributions in Shaping Public Attitudes toward People with Mental Illness’ (2000) 4 *Journal of Health and Social Behavior* 208.

pathological problems of mental illness, society has as its first line of defence, the medical profession, a topic discussed more fully in Chapter Two.

Although Australian public mental health policies have been quite pointed in the direction of a socially inclusive approach to well-being through the expression of clear social aspirations, the necessary funding to achieve these social objectives such as proper housing, employment, and improved benefits have not only been grossly inadequate but are continually subject to cuts to existing funding or services.¹⁷³ Aspirations are commonly disregarded in both an operational and public preference for maintaining basic medical care and treatment services. Mental health is still primarily understood from a medical perspective.

Law is an important public health tool because it plays a critical role in regulating and controlling behaviours because mental health is fundamentally about society's reactions and responses to the abnormal and unacceptable behaviours of people who experience a mental illness, the topic discussed in Chapter Three. The state's police powers strongly reinforce the social requirement to 'control and treat', perpetuating the very stigma and stereotypes that mental health policies aim to reduce. And according to Perlin, judges and lawyers are positioned as the incompetent and capricious agents of social control, sharing identical bias and myths with the public because, they *are* the public.¹⁷⁴ The evidence for Perlin's contentious assertion will be examined in Chapter Five.

What is obvious is that the social nature of illness is particularly evident in the stigma associated with the disease of mental illness. When a disease is stigmatised in this way, public health policies can help to protect the ill from public prejudice, or alternatively, they can help to 'promote environments in which stigma festers'.¹⁷⁵ Equally, the law is an important tool in protecting the rights of people who experience mental illness. But until clear and consistent conceptual models and definitions are developed and universally applied, mental health policies will

¹⁷³ The 2011/12 Federal Budget saw the Government make savage cuts of 400 million to the funding of GP mental health services through Medicare under the Better Access Program. The Tasmanian state government cut \$14 million from its mental health budget in the same year. See Australian Medical Association, 'Stop the Government's cuts to mental health funding' (Petition, AMA, 8 July 2011) <<http://ama.com.au/node/6870>>. And also Aimee Volkofsky, 'Rural, Regional mental health services struggle with funding cuts', *ABC* (online), 28 July 2011 <<http://www.abc.net.au/sitearchive/rural/tas/content/2011/07/s3280194.htm>>.

¹⁷⁴ Perlin, above n 8, 47.

¹⁷⁵ Patrick W Corrigan and Amy C Watson, 'Understanding the impact of stigma on people with mental illness' (2002) 1 *World Psychiatric Association* 16, 18.

continue to be plagued by vagary, confusion and inconsistent interpretations that are often driven by myths, stereotypes and ‘risk minimisation’, and people who experience a mental illness will continue to be disadvantaged by a legal system that is disconnected from the diverse, though well intentioned basic goals of public policy.

BIBLIOGRAPHY

A. Articles

Abberly, Paul, 'The Concept of Oppression and the Development of a Social Theory of Disability' (1987) 2 *Disability, Handicap and Society* 5.

Bartley, Jeffcoat, Sharon William Judge, and Sharon Judge, 'Antecedents of Marital Happiness and Career Satisfaction: An Empirical Study of Dual-Career Managers' (2007) 1 *Journal of Business and Public Affairs*
<<http://www.scientificjournals.org/journals2007/articles/1059.htm>>.

Boorse, Christopher, 'Health as a Theoretical Concept' (1977) 44 *Philosophy of Science* 542.

Braveman, Paula, 'Health Disparities and Health Equity: Concepts and Measurement' (2006) 27 *Annual Review of Public Health* 167.

Burns, Jonathan Kenneth, 'Mental Health and Inequity: A Human Rights Approach to Inequality, Discrimination, and Mental Disability' (2009) 11 *Health and Human Rights* 19.

Concha, Alvin, *et al.*, 'Concept Of Health And Health Needs Of Suburban Residents In A Developing Country: Qualitative Study' (2003) 2 *Asia Pacific Family Medicine* 107.

Conrad, Peter, and Kristin K Barker, 'The Social Construction of Illness: Key Insights and Policy Implications' (2010) 51 *Journal of Health and Social Behavior* 67.

Corrigan, Patrick W, and Amy C Watson, 'Understanding the impact of stigma on people with mental illness' (2002) 1 *World Psychiatric Association* 16.

Dewsbury, Guy, *et al.*, 'The anti-social model of disability' (2004) 19 *Disability & Society* 145.

Draine, Jeffrey, *et al.*, 'Role of Social Disadvantage in Crime, Joblessness, and Homelessness Among Persons With Serious Mental Illness' (2002) 53 *Psychiatric Services* 565.

Epperly, Ted D, and Kevin E Moore, 'Health Issues in Men: Part II. Common Psychosocial Disorders' (2000) 62 *American Family Physician* 117.

Estroff, Sue E, *et al.*, 'Pathways to Disability Income among Persons with Severe, Persistent Psychiatric Disorders' (1997) 75 *The Milbank Quarterly* 495.

Goldman, Howard H, and Gerald N Grob, 'Defining 'Mental Illness' In Mental Health Policy' (2006) 25 *Health Affairs* 737.

Goode, Judith, 'How Urban Ethnography Counters Myths about the Poor' in George Gmelch, and Gostin, Lance, 'Human Rights of Persons with Mental Disabilities: The European Convention of Human Rights' (2000) 23 *International Journal of Law and Psychiatry* 125.

Handwerker, Lisa, 'Medical risk: implicating poor pregnant women' (1994) 38 *Social Science & Medicine* 665.

Kendell, R E, 'The distinction between personality disorder and mental illness' (2002) 180 *The British Journal of Psychiatry* 110.

Kindig, David, and Greg Stoddart, 'What Is Population Health?' (2003) 93 *American Journal of Public Health* 380.

Lambert, Kelly G, 'Rising rates of depression in today's society: Consideration of the roles of effort-based rewards and enhanced resilience in day-to-day functioning' (2006) 30 *Neuroscience and Biobehavioral Reviews* 497.

Loeb, Michell E, Arne H Eide, and Daniel Mont, 'Approaching the measurement of disability prevalence: The case of Zambia' (2008) 2 *ALTER, Revue Européenne De Recherche Sur Le Handicap* 32.

Macagno, Fabrizio, 'Definitions in law' (2010) 2 *Bulletin Suisse de Linguistique Appliquée* 199.

Mantler, Janet, *et al.*, 'Coping with employment uncertainty: a comparison of employed and unemployed workers' (2005) 10 *Journal of Occupational Health Psychology* 200.

Martin, Jack K, Bernice A Pescosolido, and Steven A Tuch, 'Of Fear and Loathing: The Role of 'Disturbing Behavior,' Labels, and Causal Attributions in Shaping Public Attitudes toward People with Mental Illness' (2000) 4 *Journal of Health and Social Behavior* 208.

McNiel, Dale E, Renee L Binder, and Jo C Robinson, 'Incarceration Associated With Homelessness, Mental Disorder, and Co-occurring Substance Abuse' (2005) 56 *Psychiatric Services* 840.

Murali, Vijaya, and Femi Oyeboode, 'Poverty, social inequality and mental health' (2004) *Advances in Psychiatric Treatment* 216.

Oliver, Mike, 'Social policy and disability: some theoretical issues' (1986) 1 *Disability, Handicap and Society* 5.

Pevalin, David J, and David P Goldberg, 'Social precursors to onset and recovery from episodes of common mental illness' (2003) 33 *Psychological Medicine* 299.

Phelan, Jo C, *et al.*, 'The Stigma of Homelessness: The Impact of the Label "Homeless" on Attitudes Toward Poor' (1997) 60 *Social Psychology Quarterly* 323.

Pridmore, Saxby, *Download of Psychiatry*, Chapter 32.
<http://eprints.utas.edu.au/287/40/Chapter_32__Medicalization_of_suffering.pdf>

Räikkä, Juha, 'The social concept of disease' (1996) 17 *Theoretical Medicine and Bioethics* 353.

Roberts, Glenn, and Paul Wolfson, 'The rediscovery of recovery: open to all' (2004) 10 *Advances in Psychiatric Treatment* 37.

Seelman, Kate, 'Trends in rehabilitation and disability: transition from a medical model to an integrative model' (2004) 22 *Disability World* <www.disabilityworld.org/01-03_04/access/rehabtrends1.shtml>.

Shakespeare, Tom, and Nicholas Watson, 'The social model of disability: an outdated ideology?' (2002) 2 *Research in Social Science and Disability* 9.

Shakespeare, Tom, 'A Response to Liz Crow' (1992) *Coalition* 40.

Tarlov, Alvin R, 'Public Policy Frameworks for Improving Population Health' (1999) 896 *Annals of the New York Academy of Sciences* 281.

Theriot, Matthew T, and Steven P Segal, 'Involvement with the Criminal Justice System Among New Clients at Outpatient Mental Health Agencies' (2005) 56 *Psychiatric Services* 179.

Wilson, C E A, 'The untilled fields of public health' (1920) 51 *Science* 23.

Witmer, Melvin J and Thomas J Sweeny, 'A holistic model for wellness and prevention over the lifespan' (1992) *Journal of Counseling and Development* 140.

Zarnowitz, Vicor, 'Theory and History Behind Business Cycles: Are the 1990s the Onset of a Golden Age?' (1999) 13 *Journal of Economic Perspectives* 69.

B. Books

Anderson, Keith, *et al.* (eds), *Mosby's Medical, Nursing and Allied Health Dictionary* (Mosby, 5th ed, 1998).

Barnes, Colin, and Geof Mercer, (eds), *Doing Disability Research* (The Disability Press, 1997). Beresford, Peter, and Jan Wallcraft, 'Psychiatric System Survivors and Emancipatory Research: Issues, overlaps and differences'.

Bauman, Zygmunt, *The Individualized Society* (Polity Press, 2001).

Breslow, Lester, (ed), *Encyclopedia of Public Health*, Volume 3, (Gale Cengage, 2002).

Compton, William C, *Introduction to Positive Psychology* (Wadsworth, 2005).

Foucault, Michel, *Madness and Civilization: A History of Insanity in the Age of Reason* (Vintage Books, 1988).

Hales, Dianne, and Robert E Hales, *Caring for the Mind: The Comprehensive Guide to Mental Health* (Bantam Books, 1995).

Jahoda, Marie, *Current Concepts of Positive Mental Health* (Ayer Company Publishers, 1999).

Kemper, Robert V, and Walter P Zenner (eds), *Urban life: readings in the anthropology of the city* (Waveland Press, 2002).

Kuhn, Thomas S, *The Structure of Scientific Revolutions* (The University of Chicago Press, 2nd ed, 1970).

Lyerly, Cynthia Lynn, *Methodism and the Southern Mind, 1770-1810* (Oxford University Press, 1998).

Marks, Deborah, *Disability: controversial debates and psychosocial perspectives* (Routledge, 1999).

Oliver, Michael, *The politics of disablement* (Macmillan, 1990).

Oliver, Michael, *Understanding disability: from theory to practice* (Macmillan, 1996).

- Perlin, Michael L, *The Hidden Prejudice: Mental Disability on Trial* (American Psychological Association, 2000).
- Rath, Tom and James K Harter, *Wellbeing: The Five Essential Elements* (Gallup Press, 2010).
- Riding, Time, Caron Swant, and Bob Swann, (eds), *The Handbook Of Forensic Learning Disabilities* (Radcliffe Publishing, 2005). Turner, Steve, 'Risk assessment and management'.
- Rose, Geoffrey, *The Strategy of Preventive Medicine* (Oxford University Press, 1993).
- Ross, William David, *Plato's Theory of Ideas* (Clarendon Press, 1951).
- Russell, Julia, and Matt Jarvis, *Angles on Applied Psychology* (Nelson Thornes, 2003).
- Stahl, Michael J, (ed), *Encyclopedia of health care management* (Sage Publications, 2004).
- Stefanou, Constantin, and Helen Xanthaki, *Drafting legislation: A Modern Approach* (Ashgate Publishing, 2008).
- Tew, Jerry, (ed), *Social Perspectives in Mental Health: Developing Social Models to Understand and Work with Mental Distress* (Jessica Kingsley Publishers, 2005).
- Weare, Katherine, *Promoting mental, emotional, and social health: a whole school approach* (Routledge, 2000).
- Young, T Kue, *Population Health: Concepts and Methods* (Oxford University Press, 1998).

C. Grey Literature -Research Papers, Reports, Submissions, Letters, Memos etc

- 'A Question of Justice: Access to Participation for People with Disabilities in Contact with the Justice System (Report, Disability Council of NSW, 2003).
- 'Accessibility for the Disabled - A Design Manual for a Barrier Free Environment' (Manual, United Nations, 2003) <<http://www.un.org/esa/socdev/enable/designm/>>.
- 'Community health counselling: Policy framework and program standards' (Policy framework, Victorian Department of Human Services, February 2009).
- 'Disability Action Framework for Action 2013-2017 – A Tasmanian Government plan for people with disability' (Framework, Tasmanian Department of Premier and Cabinet, December 2012)
<http://www.dpac.tas.gov.au/divisions/cdd/policy/our_policies/disability_framework_for_action/4>.
- 'Experts by Experience: Strengthening the mental health consumer voice in Tasmania' (Research Paper, Anglicare Tasmania Anglicare Tasmania and Tasmanian Mental Health Consumer Network, 2009)
<http://www.sswahs.nsw.gov.au/mhealth/content/pdf/Experts_by_Experience.pdf>.
- 'Home Truths: Mental Health, Housing and Homelessness in Australia' (Report, Mental Health Council of Australia, March 2009)

<<http://www.mhca.org.au/documents/MHCA%20Home%20Truths%20Layout%20%20FINAL.pdf>>.

‘Let’s Get to Work: A National Mental Health Employment Strategy’ (Report, Mental Health Council of Australia, November 2007)

<<http://www.mhca.org.au/documents/MHCA-Employment%20Report-final.pdf>>.

‘Literature Review For Captivate: Local Participation for All’: (Project Funded By Disability Services Commission Department of Sport and Recreation, February 2007, <http://www.walga.asn.au/Documents/Walga/MemberResources/1623_CAPTIVATE%20Literature%20Review.pdf>.

‘National Health Priority Areas Report Mental health: A Report Focusing on Depression’ (Report No PHE 11, Commonwealth Department of Health and Aged Care, Australian Institute of Health and Welfare, 1998)

‘National Mental Health Plan 2003-2008’ (Plan, Australian

‘National Mental Health Plan’ (Plan, Department of Health and Ageing, 1992)

<[http://www.health.gov.au/internet/main/publishing.nsf/Content/8E185E7F3B574CCFCA2572220005FF0D/\\$File/plan92.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/8E185E7F3B574CCFCA2572220005FF0D/$File/plan92.pdf)>.

‘National Mental Health Policy 2008’ (Policy Report, Commonwealth of Australia, 2009)

<[http://www.health.gov.au/internet/main/publishing.nsf/Content/532CBE92A8323E03CA25756E001203BF/\\$File/finpol08.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/532CBE92A8323E03CA25756E001203BF/$File/finpol08.pdf)>.

‘*Psychosocial Disability – Position Statement* (24 November 2011) Arafmi Mental Health Carers Australia, <<http://www.arafmiaustralia.asn.au/1/post/2011/11/psychosocial-disability-position-statement.html>>.

‘Reclaiming the Social Model of Disability’ (Conference Report, Greater London Action on Disability, 2000) <<http://www.leeds.ac.uk/disability-studies/archiveuk/GLAD/Social%20Model%20of%20Disability%20Conference%20Report.pdf>>.

‘Second National Mental Health Plan’ (Plan, Australian Health Ministers, Commonwealth Department of Health and Family Services, July 1998)

<[http://www.health.gov.au/internet/main/publishing.nsf/Content/0284E597D0DD5B95CA257261001083A7/\\$File/plan2.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/0284E597D0DD5B95CA257261001083A7/$File/plan2.pdf)>.

‘The World Health Report 2001 – Mental Health: New Understanding, New Hope’ (Report, The World Health Organisation, 2001) <http://www.who.int/whr/2001/en/whr01_en.pdf>.

‘Towards a common language for Functioning Disability and Health ICF’ (Report, World Health Organisation, 2002).

‘Unravelling Psychosocial Disability: A Position Statement by the National Mental Health Consumer & Carer Forum on Psychosocial Disability Associated with Mental Health Conditions’ (Forum, National Mental Health Consumer & Carer Forum, 2011)

Advocacy Tasmania Inc., Submission to *National Disability Strategy*, November 2008.

<http://www.advocacytasmania.org.au/publications/ATI_national_disability_strategy_submission.pdf>.

Barnes, Colin and Mike Oliver, 'Disability: A Sociological Phenomenon Ignored by Sociologists' (Research Paper, June 1993) <<http://www.leeds.ac.uk/disability-studies/archiveuk/Barnes/soc%20phenomenon.pdf>>.

Dee, Michael J, 'Harsh times at the Ministry of Fear? Australia's diminished citizenship of the working poor' (Paper presented at Social Change in the 21st Century, Brisbane, 21 November 2003).

Eardley, Tony, and George Matheson, 'Australian Attitudes to Unemployment and Unemployed People' (Discussion Paper, No 102, Social Policy Research Centre, June 1999).

Finkelstein, Victor, *Attitudes and disabled people* (World Rehabilitation Fund, 1980).

Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009 – 2014' (Report, Australian Government, 2009)
<<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-f-plan09>>.

Friedli, Lynne, 'Mental health, resilience and inequalities' (Report, World Health 'Funding' (Petition, AMA, 8 July 2011) <<http://ama.com.au/node/6870>>.

Henderson, Susan, 'Mental Illness and the Criminal Justice System' (Review, Mental Health Co-ordinating Council, May 2003)
<<http://www.mhcc.org.au/documents/PosPaper%20CrimJustice%20May03.pdf>>.

Hinton, Teresa, 'My Life as a Budget Item: Disability, budget priorities and poverty in Tasmania, Anglicare Tasmania' (Research Report, Anglicare, October 2006) 27.
<http://www.anglicare-tas.org.au/docs/research/My_Life_as_a_Budget_Item_-_Disability_budget_priorities_and_poverty_in_Tasmania.pdf>.

Joyce, Maria, 'From past to present; the changing focus of public health' (MSc dissertation, University of Lincoln, unpublished)
<http://eprints.lincoln.ac.uk/1839/3/Public_health_paper.pdf>.

Karabatos, Arthur, Andrew Gill, and Andrew Crawshaw-Fardouly, 'Australian Mortgage Delinquencies by Postcode' (Report, Moody's Investor Service, 28 September 2011)
<<http://www.scribd.com/doc/66629751/Report-Aussie-Mortgage-Delinquencies-by-Postcode-Sep2011>>.

Keleher, Helen and Rebecca Armstrong, 'Evidence-based mental health promotion resource' (Report, Victorian Government Department of Human Services, 2006)
<http://www.health.vic.gov.au/healthpromotion/downloads/mental_health_resource.pdf>.

King, Michael S, 'Solution-Focused Judging Bench Book' (Report, The Australasian Institute of Judicial Administration Incorporated, 2009).

Kulkarni, Jayashri, 'The Cost of Mental Illness' (Report, Monash Alfred Psychiatry Research Centre, 2010)
<http://www.maprc.org.au/sites/www.maprc.org.au/files/THE%20COST%20OF%20MENTAL%20ILLNESS%20FINAL_0.pdf>.

Mackett, Roger, Kamalasudhan Achuthan, and Helena Titheridge, 'Reducing social exclusion by removing the barriers to everyday physical activity' (Presentation at the 2nd International Congress on Physical Activity and Public Health, Amsterdam, The Netherlands, 13-16 April 2008).

Mental Health Promotion Case Studies from Countries, A Joint Publication of the World Federation for Mental Health and the World Health Organization, (2004)
<http://www.who.int/mental_health/evidence/en/case_studies_report.pdf>

Morgan, Vera A, 'People living with psychotic illness 2010: Report on the second Australian national survey of psychotic illness' (Report, Department of Health and Ageing Australian Government, November 2011)
<<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-p-psych10>>.

Ottawa Charter for Health Promotion First International Conference on Health Promotion, Ottawa, 21 November 1986 - WHO/HPR/HEP/95.1
<<http://www.who.int/healthpromotion/conferences/previous/ottawa/en>>

Pape, Bonnie, and Jean-Pierre Galipeault, 'Mental Health Promotion for People with Mental Illness' (Discussion Paper, Mental Health Promotion Unit of Health Canada, April 2002) <http://www.phac-aspc.gc.ca/publicat/mh-sm/mhp02-psm02/pdf/mh_paper_02_e.pdf>.

Rickwood, Debra, 'Pathways of Recovery: Preventing further episodes of mental illness (monograph)' (Monograph, Commonwealth of Australia, 2006).

Submission to Productivity Commission Disability Care and Support, Mental Health Carers Arafmi Australia, April 2011.
<http://www.arafmiaustralia.asn.au/uploads/7/2/8/9/7289235/mhcaa_submission_to_productivity_commission_-_april_2011.pdf>.

Szirom, Tricia, Debbie King, and Kathy Desmond, 'Barriers To Service Provision For Young People With Presenting Substance Misuse And Mental Health Problems' (Report, Australian Government Department of Family and Community Services, October 2004).

Turrell, Gavin, *et al.*, 'Health Inequalities in Australia: Morbidity, health behaviours, risk factors and health service use' (Report No 2, Queensland University of Technology and the Australian Institute of Health and Welfare, March 2006)
<<http://www.aihw.gov.au/publications/phe/hiamhbrfhsu/hiamhbrfhsu.pdf>>.

D. International law instruments

Convention on the Rights of Persons with Disabilities.

Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.

E. Legislation

Alcohol and Drug Dependency Act 1968 (Tas).

Anti-Discrimination Act 1998 (Tas).

Disability Discrimination Act 1992 (Cth).

Disability Services Act 1986 (Cth).

Disability Services Act 1992 (Tas).

Disability Services Act 2011 (Tas).

Guardianship and Administration Act 1995 (Tas).

Mental Health Act 1996 (Tas).

Mental Health Act 2013 (Tas)

Mental Health Act 1996 (WA).

F. Media and websites

‘Mental Illness and Homelessness’ (Fact Sheet No 5, National Coalition for the Homeless, June 2006) <http://www.nationalhomeless.org/publications/facts/Mental_Illness.pdf>.

Australian Government, JobAccess - help and workplace solutions for the employment of people with disability,
<http://jobaccess.gov.au/ServiceProviders/Assisting_job_seekers/Supporting_jobseekers_with_different_types_of_disability/What_is_disability/Pages/Understanding_winder_deba.aspx>

Baker, Dr Ken, *National Disability Services, Link Disability Magazine*
<<http://www.linkonline.com.au/Link/article/169>>.

Beyondblue <<http://www.beyondblue.org.au/>>.

Victoria Legal Aid, *Mental health and your rights*
<<http://www.legalaid.vic.gov.au/mentalhealth.htm>>.

Volkofsky, Aimee, ‘Rural, Regional mental health services struggle with funding cuts’, *ABC* (online), 28 July 2011
<<http://www.abc.net.au/sitearchive/rural/tas/content/2011/07/s3280194.htm>>.

World Health Organization, *Strengthening Mental Health Promotion. Geneva: World Health Organization (Fact Sheet, No. 220); 2001b.*

CHAPTER TWO

MENTAL ILLNESS: SOCIAL, MEDICAL AND LEGAL LABELLING

1. INTRODUCTION

Chapter Two has two related purposes. First, it examines the conceptual and definitional problems associated with achieving a clear and unified acceptance of what mental illness means in law. While the law has wholly incorporated the biomedical notions of mental illness that was explored in Chapter One, it has not defined the term with any more precision. Legal definitions tend to be generalised, broad, vague, ambiguous, and having ‘circular definitions that contain few limitations’¹ so as to permit, and mask ‘arbitrariness and discrimination in the application of the law’.²

Secondly, it demonstrates that the clinical labelling of ‘mental illness’ is achieved through an observation process that arrives at value laden, unreliable and inconsistent, qualitative guesses by mental health professionals. The diagnostic and social labelling of a person as ‘mentally ill’ tags them as abnormal, different, disabled and dysfunctional, characteristics that are reinforced, and perpetuated, by a legal system well rooted in the medical model of treatment and control, and reliant on psychiatric predictions of risk and future behaviour.

In the rational world, psychiatrists have long been tasked with responsibility for understanding the causes and nature of irrationality, and treating and controlling the abnormal and socially unacceptable manifestations of mental illness. It is therefore understandable that psychiatry has infiltrated itself into every aspect of legal matters in which a party is alleged to be experiencing a mental illness, and credibility, culpability, competency, compensation and custody are at issue.³ The clinical

¹ Bruce J Winick, ‘Ambiguities In The Legal Meaning And Significance Of Mental Illness’ (1995) 1 *Psychology, Public Policy, and Law* 534, 554.

² Ibid 555.

³ Ralph Slovenko, *Psychiatry in Law, Law in Psychiatry* (Routledge, 2009) xi.

opinion of the psychiatrist expert witness strongly influences judicial decision-making and yet, as this chapter shows, the foundation on which the psychiatric expert's evidence rests is flawed. The legal system's willingness to accept pretextual pseudoscientific evidence based on intuitive, unreliable and often incorrect diagnoses continues to propagate the law's discrimination of a vulnerable, disadvantaged and marginalised group of people who experience mental illness.

2. 'MENTAL ILLNESS' IN THE LEGAL CONTEXT

A medical condition that deviates from what is considered to be a socially acceptable, 'normal' non-contagious disease such as cancer or diabetes usually attracts a significant level of legal intervention through the enactment of control and compulsion legislation. In Tasmania, the *HIV/AIDS Preventive Measures Act* 1993 provides measures for the prevention and containment of HIV/AIDS, the protection and promotion of public health, and appropriate treatment, counselling and care of persons infected with HIV/AIDS, or at risk of HIV/AIDS infection. S.47 (a) of the *Tasmanian Anti-Discrimination Act* 1998 also makes it lawful to discriminate against a person with an infectious disease such as AIDS. However, globally, there is no illness that has historically attracted even close to the levels of restrictive interaction with the legal system than mental illness.

Over the centuries, the law has developed particular rules to deal with the problems caused by the socially unacceptable, abnormal behaviours associated with, if not actually being acted out at the time by, people experiencing a mental illness. The application of these special regulatory rules to a particular social group is considered by some commentators as discriminatory⁴ although others believe that 'special rules to deal with at least some people with mental disorder are justified because they substantially lack rational capacity, a condition that justifies disparate treatment.'⁵ While at times may behave differently, the majority of people who experience mental illness are usually considered sufficiently like 'normal' people

⁴ Stephen Rosenman, 'Mental Health Law: An Idea whose Time has Passed' (1994) 28 *Australian New Zealand Journal of Psychiatry* 560.

⁵ Stephen J Morse, 'Mental Disorder and Criminal Law' (2011) 101 *The Journal of Criminal Law & Criminology* 885, 885.

that they are treated in the same way, and are held equally as responsible for their behaviours as people who are not experiencing a mental illness.⁶

Although both the legal and mental health systems are concerned with understanding and controlling human behaviour, they approach the task differently. Law is a normative enterprise which views almost everyone as responsible for their actions, and the consequences that flow directly from those actions. The legal system's approach is in terms of moral evaluation and the imposition of values, adhering to the principle that all people have free will and choose how it is that they will behave, so are morally and legally responsible for their behaviour.⁷ While the legal system adequately interprets, and addresses the problems associated with normal behaviour it is ill-equipped to do so in matters of abnormal, irrational behaviour.

Biological, psychological, and sociocultural factors or pressures can affect choices of action which can impact on the law's imposition of legal responsibility on a person. The socially held rational model of behaviour is unable to explain why a person would choose to behave in an abnormal way which inevitably leads to the intuitive conclusion that the person cannot, or has great difficulty in controlling their behaviour. This view comports with, and is reinforced by the biomedical model in which free will or personal responsibility have little meaning. Medicine views responsibility as a scientifically irrelevant, moral term.⁸

2.1 The law and the biomedical notion of mental illness

Society and the legal system have always been confused and often frightened by mental disorder.⁹

Determining whether the person has a mental illness is the necessary yardstick in legal areas such as criminal law, contract law, succession, financial administration, civil commitment, guardianship and family law in which competency, capacity and culpability are at issue. In evaluating competency, capacity and culpability, the legal system relies on the biomedical model which advances the claim that mental

⁶ Stephen J Morse, 'Crazy Behavior, Morals and Science: An Analysis of Mental Health Law' (1978) 51 *Southern California Law Review* 527. See also Stephen J Morse, 'Mental Disorder and Criminal Law' (2011) 101 *The Journal of Criminal Law & Criminology* 885.

⁷ Ibid.

⁸ Ibid.

⁹ Ibid, 530.

illness is the same as physical illness, and that people who experience mental illness require medical management. Mentally disordered behaviour is considered to be a symptom of a mental illness, and the person who is in a mentally disordered state has no, or limited, control over their behaviour. The implication is that if the person is sick then they should be exempted from their responsibilities, and be given care and treatment rather than punishment.¹⁰

In legal matters in which mental illness is a significant factor, courts often base their decisions on the clinical information contained within psychiatric evaluation/reports and/or on expert psychiatric witness testimony. Psychiatry plays an important role in establishing, for the court's benefit, whether the person has a mental illness that satisfies the statutory definition; whether the person experiencing a mental illness had a 'guilty mind' at the time of committing an offence, an essential element of criminal law; whether the person possessed the requisite capacity for a 'meeting of minds' in contract law; or whether the person was of 'sound mind' when writing their will.¹¹

By its acceptance of the biomedical notion of mental illness, the law has created a forum in which psychiatrists are all knowledgeable, and all powerful. When issues of a person's present or predictive abnormal behaviours are brought into the legal system so they may be potentially deprived of their rights and responsibilities, courts call on mental health professionals to help resolve the issue, and to legitimise the decisions made which are often, the legal ratification of a scientific judgement although, as shown in this chapter (see below at 3.5), there is very little science in a psychiatric opinion.

The public treats a person experiencing a mental illness differently because of its prejudicial belief in the inferiority of the person. This is discussed in detail in Chapter Three. The law however, treats them differently because of its perception of the uncontrollable, wrongness of the person's mental functioning, and the predictive assessment of their future, undesirable behaviour. This treatment difference is evident in practically every area of civil and criminal law on occasions when a person's competency, responsibility and capability are brought into

¹⁰ Talcott Parsons, *The Social System* (Tavistock, 1952).

¹¹ Slovenko, above n 3.

question, or the public's interest in the preventative need to involuntarily detain and treat are deemed key factors in arriving at a desired legal outcome.

2.2 Legally defining 'mental illness'

There is a traditional acceptance that medical definitions consist of vague generalities with an emphasis on symptoms, disability or distress.¹² Clinical definitions of mental illness suffer from the ambiguities found in the Diagnostic and Statistical Manual of Mental Disorders IV and Diagnostic and Statistical Manual of Mental Disorders V (DSM IV and DSM V)¹³, the system of mental disorder classifications of mental disorders used by psychiatrists to diagnose their patients. Overlapping categories and the absence of defined borders among conditions which affect different systems simultaneously results in definitions that satisfy clinical purposes but lack legal functionality.¹⁴ Legal definitions on the other hand, emphasise constructs of incapacity, incompetence and culpability, and differ according to whether the definition is for the purposes of civil or criminal law.

There exists a need for linguistic clarity and consistency in law. Terminological clarity is a prerequisite for the clear thought and analysis¹⁵ that are necessary attributes for academic discussion, strategic planning, legislative drafting and interpretation, and legal decision-making. How terms are interpreted can have important practical consequences, particularly to the person being classified as 'mentally ill' or 'mentally disordered'.¹⁶ A universally accepted definition can help settle the normative issue of, for example, when an offender is sentenced to psychiatric hospital care instead of prison.¹⁷ That there are no clear and precise legal definitions is not surprising considering that there are also no agreed medical definitions for 'mental illness', 'mental disorder' and 'mental disease'.

¹² Joseph M Livermore, Carl P Malmquist and Paul E Meehl, 'On the Justifications for Civil Commitment' (1968) 117 *University of Pennsylvania Law Review* 75.

¹³ The DSM was first published in 1952. The previous version, the DSM-IV was published in 1994 by the American Psychiatric Association. A text revision of DSM-IV, called DSM-IV-TR was published in July 2000. The current version, the DSM V was publically released in May, 2013.

¹⁴ In David N Weisstub (ed.), *Research on Human Subjects: Ethics, Law, and Social Policy* (Pergamon, 1998). Arboleda-Flórez, J., Weisstub, D.N., Ethical Research with Vulnerable Populations: The Mentally Disordered, pp. 433-450.

¹⁵ Pierre Beumont and Terry Carney, 'Can psychiatric terminology be translated into legal regulation? The anorexia nervosa example' (2004) *Australian and New Zealand Journal of Psychiatry* 819.

¹⁶ Bengt Brulde, 'On defining "mental disorder": Purposes and conditions of adequacy' (2010) 31 *Theoretical Medicine and Bioethics* 19.

¹⁷ Ibid.

Recent decades have demonstrated a trend of circularity in legislatively defining ‘mental illness’ which is perhaps best apparent in the development of the United Kingdom’s recent mental health legislation. Prior to 2007, ‘mental disorder’ was very loosely defined as ‘mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind’.¹⁸ These four broad categories captured intellectual disability, autism, dementia, personality disorders, drug and alcohol dependence etc. under the Act. The *Mental Health Act* 2007 replaced the categories with a single definition of mental disorder which ‘means any disorder or disability of the mind’ with the new Act omitting altogether the term ‘mental illness’.¹⁹ Jurisdictions across the world share similar definitional provisions to the UK.

This was the situation in Tasmania until very recently. The previous 1996 Act²⁰ similarly captured disabilities such as autism and dementia. The newly enacted 2013 Act defines mental illness as a mental condition which a person experiences, temporarily, repeatedly or continually, that is a serious impairment of thought and includes delusions, or is a serious impairment of mood, volition, perception or cognition. It expressly excludes a list of conditions including intellectual or physical disability, acquired brain injury and dementia.²¹

The medical approach toward defining the term can be seen in the United Kingdom (UK), Department of Health memorandum that claims that the term’s ‘operational definition and usage is a matter for clinical judgment’.²² The law has historically agreed. ‘Mental illness is a medical concept, and so it would seem self-evident that its definition should come from the medical profession and not from either legislators or judges.’²³ Turning to the medical profession has, however, failed to provide the law with any clear answers²⁴ and any expectation that judges might themselves provide a clear definition has gone unrealised as they have shown

¹⁸ *Mental Health Act* 1959 Chapter 72, Part 1 (4) (1); *Mental Health Act* 1983 Chapter 20, Part 1 (1)(2)

¹⁹ *Mental Health Act* 2007 (UK) s 1(2) amended the 1983 Act’s definition of “mental disorder”. See also *Mental Health Act* 2007 (NSW) s 4(c).

²⁰ *Mental Health Act* 1996 (Tas) s 4(1).

²¹ *Mental Health Act* 2013 (Tas) s 4(1).

²² Department of Health and Welsh Office, Memorandum on Parts of the Mental Health Act 1998: Para 10

²³ Henry Weihofen, ‘The Law and the Mentally Ill: The Definition of Mental Illness’ (1960) 21 *Ohio State Law Journal* 1.

²⁴ *Ibid.*

themselves none too anxious to define ‘mental illness’.²⁵ Having accepted the medical framework but finding it conceptually and definitionally lacking for legal purposes, the law has turned to ordinary language definitions that suggest that mental illness is, for legal and lay purposes, a label for incomprehensible conduct.²⁶

Rather than taking the opportunity to provide a clear judicial interpretation of mental illness, and prior to that, ‘unsound mind’²⁷, courts have permitted the tautological definitions to stand unclarified, and have shown a willingness to accept mental illness as whatever society says it is. In *Buxton v Jayne*, Lord Devlin stated he ‘was not going to attempt a definition of just what is meant by unsound mind, an expression which the Act itself leaves undefined, nor am I going to search for equivalent language’.²⁸ In 1974, Judge Lawton noted in *W v L*²⁹ that:

The facts of this case show how difficult the fitting of particular instances into the statutory classification can be. Lord Denning MR and Orr LJ have pointed out that there is no definition of “mental illness”. The words are ordinary words of the English language. They have no particular medical significance. How should the court construe them? The answer in my judgement is to be found in the advice which Lord Reid recently gave in *Cozette v Brutus* [1973] AC854 p.861 namely, that ordinary words of the English language should be construed in the way that ordinary sensible people would construe them. That being, in my judgment, the right test, then I ask myself, what would have the ordinary sensible person said about the patient’s condition in this case if he had been informed of his behaviour to the dogs and cat and his wife? In my judgment such a person would have said: “Well, the fellow is obviously mentally ill”.³⁰

Courts apply ‘the man must be mad’ or ‘what the ordinary sensible person would do and think’ lay discourse tests on a case by case basis. The problem is that these tests rely on the ordinary person’s misinformed, stereotypical and discriminatory attitudes toward non-conformist behaviour to establish the presence of a mental

²⁵ John O’Sullivan, *Mental Health and the Law* (The Law Book Company, 1981).

²⁶ David Pilgrim and Anne Rogers, *A Sociology of Mental Health and Illness* (Open University Press, 1999).

²⁷ Anselm Eldergill, *Mental Health Review Tribunals: Law and Practice* (Sweet & Maxwell 1997).

²⁸ [1960] 2 All ER 688 at 697.

²⁹ *W v L* [1974] QB711 688.

³⁰ *Ibid*, Lawton LJ.

illness.³¹ It is merely an observation about madness that says nothing about what constitutes a mental illness.³² It also wrongly assumes that there exists a standard shared view among lay people as to what mental illness is,³³ but as Morse indicates, society is just as confused by mental illness as the legal system is.³⁴

2.3 Australia's mental health laws

Australian jurisdictions have readily given statutory definition to mental illness in the civil commitment forum, albeit with varying degrees of uniformity, clarity and worth. Here, mental health acts are purposive with dichotomous streams of paternalism and protectionism converging at a single point: treatment.³⁵ They therefore tend to focus on the practical application of symptom presentation which can be treated or controlled rather than on theoretical values. However, psychopathological definitions of mental illness are considered to be notoriously difficult to draft. If framed too narrowly they are said to deny services to people but if framed too broadly, they can result in unnecessary intervention.³⁶ This concern is commonly used as a rationale for why statutory definitions of mental illness are fairly fluid.³⁷ The consequence of fluidity is that mental health acts differ significantly across Australian jurisdictions.

As the law is concerned with regulating, controlling and treating socially unacceptable, abnormal behaviours, having the 'appearance' of a mental illness³⁸ is often the requisite for the lawful deprivation of a person's autonomous rights and freedoms. The law concentrates on establishing indicia - signs, symptoms and behaviours – which provide the evidence the courts uses to justify its discriminatory treatment of people experiencing a mental illness.

³¹ Lawrence Gostin, *Mental health services: law and practice* (Shaw & Sons, 1986).

³² Brenda Hale, *Mental Health Law* (Sweet & Maxwell, 5th ed, 2010).

³³ Michael Cavadino, 'Mental illness and neo-Colonialism' (1991) 2 *Journal of Forensic Psychiatry* 295.

³⁴ Morse, above n 6. See also Stephen J Morse, 'Mental Disorder and Criminal Law' (2011) 101 *The Journal of Criminal Law & Criminology* 885.

³⁵ *Mental Health Act 2007* (NSW) s 4 amended the 1983 Act, replacing the 'treatability test' with the 'appropriate treatment test'.

³⁶ Beth Wilson, 'Legal Straitjackets: When Reason Fails: Law and Mental Illness' in Hugh M Selby (ed), *Tomorrows Law* (Federation Press, 1995) 312.

³⁷ Beaumont and Carney, above n 15.

³⁸ *Mental Health Act 1996* (Tas) s 24(a).

Table 1 below demonstrates the symptoms/sign focus of Australian mental health legislation.

Table 1	Australian statute definitions for mental illness
New South Wales <i>Mental Health Act</i> 2007 s.4(1)	‘a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms: (a) delusions, (b) hallucinations, (c) serious disorder of thought form, (d) a severe disturbance of mood, (e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)-(d).
Tasmania <i>Mental Health Act</i> 2013 s.4(1)	(a) a person is taken to have a mental illness if he or she experiences, temporarily, repeatedly or continually – (i) a serious impairment of thought (which may include delusions); or (ii) a serious impairment of mood, volition, perception or cognition; and (b) nothing prevents the serious or permanent physiological, biochemical or psychological effects of alcohol use or drug-taking from being regarded as an indication that a person has a mental illness.
Queensland <i>Mental Health Act</i> 2000 s.12(1)	Mental illness is a condition characterised by a clinically significant disturbance of thought, mood, perception or memory.
Victoria <i>Mental Health Act</i> 1986 s.8(1A)	a person is mentally ill if he or she has a mental illness, being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.’
South Australia <i>Mental Health Act</i> 1993 S.3	"mental illness" means any illness or disorder of the mind;
Western Australia <i>Mental Health Act</i> 1996 s.4(1)	For the purposes of this Act a person has a mental illness if the person suffers from a disturbance of thought, mood, volition, perception, orientation or memory that impairs judgment or behaviour to a significant extent. Western Australia doesn't specifically define it at all but identifies a person as having a mental illness if they suffer 'from a disturbance of thought, mood, volition, perception, orientation or memory that impairs judgment or behaviour to a significant extent'.
Australian Capital Territory <i>Mental Health (Treatment and Care) Act</i> 1994 s.3	mental illness means a condition that seriously impairs (either temporarily or permanently) the mental functioning of a person and is characterised by the presence in the person of any of the following symptoms: (a) delusions; (b) hallucinations; (c) serious disorder of thought form; (d) a severe disturbance of mood; (e) sustained or repeated irrational behaviour indicating the presence of the symptoms referred to in paragraph (a), (b), (c) or (d).

Table 1	Australian statute definitions for mental illness
Northern Territory <i>Mental Health and Related Services Act</i> S. 6(1)	"mental illness" means a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person in one or more of the areas of thought, mood, volition, perception, orientation or memory and is characterised: (a) by the presence of at least one of the following symptoms: (i) delusions; (ii) hallucinations; (iii) serious disorders of the stream of thought; (iv) serious disorders of thought form; (v) serious disturbances of mood; or (b) by sustained or repeated irrational behaviour that may be taken to indicate the presence of at least one of the symptoms referred to in paragraph (a).

In contrast to the present Australian focus on biomedical symptomology, Florida recently enacted legislation that appears to be an attempt to align the implementation of the state's mental health law with the direction of its mental health policies. The Act³⁹ broadly defines 'mental illness' as 'an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology'.⁴⁰ Involuntary examination is authorised for someone considered likely to suffer from neglect that 'poses a real and present threat of substantial harm to his or her well-being'.⁴¹ It was WHO that defined mental health as a state of well-being.⁴² With the insertion of terms such as 'ordinary demands of living' and 'regardless of etiology' into legislation, mental illness appears in some jurisdictions to no longer be constrained within statutory confines of biomedicine and its focus on treatment and control but is branching out into a much broader social paradigm with its new functionalist test of expected performance.

It seems that increasingly, it is the lack of well-being - the state of being healthy, happy, or prosperous - that is becoming the driving indicator for state intervention in the social lives of citizens.⁴³ How the future role of the law might be interpreted within this broader social/medical/legal process, and how it will be applied to individual cases requires serious academic and judicial discussion which, to date,

³⁹ *Florida Mental Health Act* ss. 394.455 (18) (2009)

⁴⁰ *Ibid.*

⁴¹ *Ibid.*

⁴² World Health Organization, 'Mental health: a state of well-being' (Report, World Health Organization, October 2011) <http://www.who.int/features/factfiles/mental_health/en/index.html>.

⁴³ Interestingly, Florida is ranked 49th in the U.S. for per-capita spending on mental health care and 35th in substance abuse care. Ralph De La Cruz, 'Mental Health Funding at Risk', *Florida Centre for Investigative Reporting* (online), 9 March 2011 <<http://fcir.org/2011/03/09/mental-health-funding-at-risk/>>.

has not occurred. The process is likely to result in many more people being labelled as experiencing a mental illness and as a consequence, experiencing stigma, social marginalisation and legal discrimination. A first step toward preventing, or minimalising, this occurrence is to redress the present conceptual and definitional inconsistencies and ambiguities that exist in the legal system.

3. BIOMEDICINE: THE FOUNDATION OF MENTAL HEALTH LAW

Mental health is an area unlike any other, in which the medical, political and legal systems have aligned to deprive the members of a large, marginalised group consisting of approximately one fifth of the world's population, of basic freedoms on the basis of intuitive, unreliable and often incorrect psychiatric diagnoses. People experiencing a mental illness are disempowered by systems juggling the weight of medical guesswork and value-laden judgments: conflicted and inconsistent mental health policies; non-existent, tautological, or inadequate definitions; paternalism and public safety issues are weighed against the, often feather light, rights of the individual diagnosed with a mental illness.

Mental illness is commonly regarded as an indicator of suffering, vulnerability and neglect for an individual that not only justifies, but obligates the state to intervene by authority of its paternalistic beneficence and public safety powers. It is the biomedical model that has had dominance in shaping society's understanding of mental illness.⁴⁴ Reasons for this might include the model's long history and its embeddedness within medical thought and practice; the prestige and authority associated with its scientific foundation; its strong explanatory power; the intuitive understanding of medical disease; and the beneficial connectivity that disease has with treatment.

3.1 The pathology of disease

During the first half of the 20th century, psychiatrists took a psychoanalytic approach to treatment which made them unconcerned with actual diagnoses. This

⁴⁴ Peter Beresford, Mary Nettle and Rebecca Perring, 'Towards a social model of madness and distress? Exploring what service users say' (Report, Joseph Rountree Foundation, 2010) <<http://www.jrf.org.uk/publications/social-model-madness-distress>>.

changed in the early 1950s when clinicians began labelling psychiatric disorders as particular diagnostic entities and a mental disease or mental disorder became a pathological problem. At this time, psychiatry adopted the medical model with its assumption that a disease has three components: an etiological agent, a pathological process, and symptoms and signs.⁴⁵ Current medical practice is dominated by the biomedical model of health with its reliance on signs/symptoms.⁴⁶

The biomedical disease model assumes that the disease is a temporary organic condition experienced by a sick individual who then becomes an object of medical intervention, the objective of which is to cure or eradicate the disease which makes making the application of medicine a reactive healing process.⁴⁷ Non-organic factors associated with the human mind are viewed as unimportant, or are ignored altogether in the search for biological causes of pathological symptoms.⁴⁸ Treatment is then administered, usually in a medical environment such as a surgery or a hospital, in response to the symptomatic features of the illness, disease or injury in accordance with the treatment choices that invariably flow from the medical diagnosis.⁴⁹

To date, mental health commentators have not reached universally accepted meanings for ‘mental illness’ and ‘mental disorder’. Even WHO expressly refused to define the terms. The *International Classification of Diseases* (ICD10)⁵⁰ ‘used the term “disorder” throughout the document to avoid even greater problems inherent in the use of terms such as “disease” and “illness”.’⁵¹ No matter what terminology is actually used however, words such as illness, disorder, disease, diagnosis, symptoms, hospitalisation and treatment all arise out of the biomedical model approach to mental health. The lay person tends to view ‘disease’ and

⁴⁵ Ahmed Aboraya *et al.*, ‘The Validity of Psychiatric Diagnosis Revisited: The Clinician's Guide to Improve the Validity of Psychiatric Diagnosis’ (2005) 2 *Psychiatry* 48.

⁴⁶ Mladen Havelka, Jasminka Despot Lucanin and Damir Lucanin, ‘Biopsychosocial model--the integrated approach to health and disease’ (2009) 33 *Collegium Antropologicum* 303.

⁴⁷ Tony Bilton *et al.*, ‘Health, Illness and Medicine’ in Tony Bilton *et al.*, *Introductory Sociology* (Palgrave Macmillan, 4th ed, 2002) 354.

⁴⁸ *Ibid* 354.

⁴⁹ *Ibid*.

⁵⁰ ICD-10 was endorsed by the Forty-third World Health Assembly in May 1990 and came into use in WHO Member States as from 1994. It is an international standard diagnostic classification for all general epidemiological, many health management purposes and clinical use.

⁵¹ World Health Organisation, ‘ICD-10 Classification of Mental and Behavioural Disorders’ (Clinical descriptions and diagnostic guidelines, World Health Organisation (2010) 5
<<http://www.who.int/classifications/icd/en/bluebook.pdf>>.

‘illness’ as synonymous⁵² which may be a contributor to the conceptual and definitional problems that exist across the totality of mental health understanding.

3.2 The separate concept of mental disease

Psychiatry has an altogether separate status to general medicine. The reason for this is probably rooted in the claim that physical and mental disorders ‘are two separate concepts that can be definitively recognised and differentiated’.⁵³ Physical illness is much more likely than mental illness to have an agreed diagnosis, a clear course of treatment and an expected recovery time.⁵⁴ Psychiatrists are more concerned with the classification and treatment of mental disorders than in attempting to formulate a definitive statement as to what mental illness is. Psychiatry reduces mental illness to an intuitive judgment of the causative presence of a mental disorder and it is preoccupied with the identification of mental disorders and the narrow technical solutions that flow from the medical model.⁵⁵

The goal of psychiatric practice is to alleviate the symptoms of the diagnosed disorder,⁵⁶ expressed in unacceptable behavioural manifestations. Treatment is commonly the dispensement of psychotropic drugs⁵⁷ which for most mental disorders is aimed solely at providing the person with relief.⁵⁸ However, the effectiveness of these drug treatments has been called into question particularly when considered alongside their known side effects. In a 2011 Canadian judgment, for example, the court found that the antidepressant Prozac was the cause of a murder. It had affected the defendant’s behaviour and judgement, thereby reducing his moral culpability for the crime.⁵⁹ Manufacturer warnings regarding the possible serious behavioural and emotional changes, and suicidality associated with

⁵² Beumont and Carney, above n 15.

⁵³ Genevra Richardson, ‘Balancing autonomy and risk: A failure of nerve in England and Wales’ (2007) 30 *International Journal of Law and Psychiatry* 71, 73.

⁵⁴ Karin A Guiduli, ‘Challenges for the mentally ill: the “threat to safety” defence standard and the use of psychotropic medication under title one of the Americans with Disabilities Act of 1980’ (1996) 144 *University of Pennsylvania Law Review* 1149.

⁵⁵ Joanna Moncrieff, ‘Is Psychiatry for Sale: An examination of the influence of the pharmaceutical industry on academic and practical psychiatry’ (Maudsley Discussion Paper, Institute of Psychiatry, 2003) <<http://www.critpsynet.freeuk.com/pharmaceuticalindustry.htm>>.

⁵⁶ Rachael Anderson-Watts, ‘Recognizing Our Dangerous Gifts: Applying the Social Model to Individuals with Mental Illness’ (2008) 12 *Michigan State University Journal of Medicine and Law* 141, 147.

⁵⁷ Helen Lester and Jonathan Q Tritter, ‘“Listen to my madness”: understanding the experiences of people with serious mental illness’ (2005) 27 *Sociology of Health & Illness* 649, 658.

⁵⁸ Saxby Pridmore, *Psychiatry*, Chapter 1, University of Tasmania EPrint, p. 8. <http://eprints.utas.edu.au/287/2/Chapter_1_Introduction_to_psychiatry%5B1%5D.pdf>

⁵⁹ *Her Majesty the Queen and C.J.P.* (Citation #2011 MBPC 62) September 16, 2011, per Heinrichs, R, P.J., at n.50

antidepressants are extensive.⁶⁰ Yet mental health practitioners continue to prescribe them widely for depression: to correct the chemical imbalance brought on by low serotonin although research has shown that low serotonin does not cause depression.⁶¹ Other research suggests that antidepressants are little more effective than placebos with dangerous side effects.⁶² It appears that people labelled as ‘mentally ill’ are treated with, sometimes ineffective although always dangerous, drugs, often involuntarily, as a means to control and alleviate behaviours that frequently have unknown causes.

3.3 Diagnosing mental illness

Diagnoses of mental illness are based on symptomology rather than etiology because the causes of serious mental illnesses are unknown. The mental health diagnosis is essentially a label applied to a set of signs/symptoms commonly occurring together that have actually been observed, or have been extracted from the patient’s medical history. This diagnostic label cannot be scientifically tested and proven, yet it, and the predictive conclusions that it engenders are the evidence that guides legal decision-makers in matters in which mental illness is a factor.

Mental illness suggests the presence of a clinically diagnosable disorder that significantly interferes with an individual’s cognitive, emotional or social abilities.⁶³ Yet ‘mental illness’ is not an exact term and nor does it have a single definition. To understand its meaning depends on the social, cultural, economic and legal context in which it is being used. Its contemporary use among mental health professionals and commentators is as an umbrella term encompassing the many differently categorised mental disorders.

Describing a person as experiencing a ‘severe mental illness’ or ‘serious mental illness’, is an indication of their mental disorder which typically, involves

⁶⁰ Subject: Stronger WARNING for SSRIs and other newer anti-depressants regarding the potential for behavioural and emotional changes, including risk of self-harm, Eli Lilly Canada Inc, May 18, 2004, Health Canada, <http://www.hc-sc.gc.ca/dhp-mps/medeff/advisories-avis/prof/_2004/prozac_hpc-cps-eng.php> See also Lexapro warning at <http://www.frx.com/pi/Lexapro_pi.pdf>; Paxil warning at <http://us.gsk.com/products/assets/us_paxil.pdf>.

⁶¹ ‘When it comes to Depression, Serotonin Isn’t the Whole Story’, *shots Health News from npr*, transcript of radio discussion, 23 January 2012, 2010 <<http://www.npr.org/templates/transcript/transcript.php?storyId=145525853>>.

⁶² Irving Kirsch *et al.*, ‘Initial Severity and Antidepressant Benefits: A Meta-Analysis of Data Submitted to the Food and Drug Administration’ (2008) 5 *Public Library of Science Medicine* 0260.

⁶³ Australian Health Ministers, ‘National Mental Health Plan 2003-2008’ (Plan, Australian Government, July 2003) 5.

psychosis, high levels of care, and hospitalisation. The two most common of these are schizophrenia and bipolar disorder. A mental disorder exists when psychological systems of perception, thinking, cognition, emotion, motivation, language or memory do not function appropriately.⁶⁴ Standards of appropriateness are not universal properties but are culturally specific norms that regulate individual behaviour to ensure it meets social expectations of what is socially acceptable. If a person has a mental disorder it implies that they have a clinically recognisable set of symptoms or behaviours which, in most cases, are associated with distress and dysfunction existing within them.⁶⁵

Diagnosing mental illness has a far greater evaluative component than diagnosing a somatic illness which can be scientifically substantiated. A mental disorder diagnosis rests predominantly on ‘a judgment made on a particular desirability or undesirability of an experience.’⁶⁶ Psychiatrists attempt to define mental disorders that are unobservable, hypothetical constructs in terms of observable behaviours, and through the self reporting of their patients. They do not directly observe the disorder, only the behaviour and subjective mental state of the person that are typed as indicators of the presence of the disorder. This has been allegorised as being akin to diagnosing a broken leg based on certain patient symptoms without taking an x-ray of the limb.⁶⁷ There may be some factual components evident, as in certain abnormalities, biochemical levels and neuro-physiological disturbances present in the brain of a person with depression but they do not have the same robustness as the facts of other medical conditions.

3.4 Classifying mental disorders

The diagnosis of a mental disorder is primarily reliant on the system of classifications listed in two professional publications, the Diagnostic and Statistical Manual of Mental Disorders (DSM) and, the International Classification of

⁶⁴ Allan V Horwitz, *Creating Mental Illness* (The University of Chicago Press, 2002) 22.

⁶⁵ World Health Organisation, ‘ICD-10 Classification of Mental and Behavioural Disorders’ (Clinical descriptions and diagnostic guidelines, World Health Organisation, 2010, 5 <<http://www.who.int/classifications/icd/en/bluebook.pdf>>.

⁶⁶ Dr Michael Robertson, Senior Consultant Psychiatrist, Centre for Values, Ethics & Law in Medicine, University of Sydney, *ABC Radio National* interview with Natasha Mitchell, 18 April, 2009 <<https://whyweprotest.net/community/threads/abc-oz-interviews-cchrs-thomas-szasz.38097/>> See also Elijah Millgram, ‘*Practical Induction*’ (Harvard University Press, 1997).

⁶⁷ Brad Johnson, ‘Prophecy with Numbers: Prospective Punishment for Predictable Human Behaviour?’ (2005) 7 *University of Technology Sydney Law Review* 117.

Diseases (ICD -10).⁶⁸ Critiques of the new DSM V refer to the manual as a primarily commercial compendium of expert opinions presented as scientific truths.⁶⁹ Critics suggest that the American Psychiatric Association has arbitrarily, and unwisely, encouraged doctors to diagnose bogus mental illnesses such as binge eating disorder in their patients, and to treat them with too much medication.⁷⁰ The DSM V's diagnostic inflation turns normal people, particularly children, into mental health patients.⁷¹

According to the DSM-V, a 'mental disorder,' must comprise a manifestation of a behavioural, psychological or biological dysfunction in the person. It is:

a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress ... or disability ... or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom ...

Criticisms of the classification systems are that they do not define disorders in terms of their causes but only of their symptoms and that mental disorders are defined as discrete categories rather than as continuous dimensions.⁷² The classification system fundamentally changed the relationship between mental illness and normality. Where previously, psychotic behaviours had been easily distinguishable from normal behaviours, the categorisation of the new neurotic behaviours such as sexual perversions, obsessions, compulsions, phobias and anxiety weren't considered as forms of an illness but as exaggerations of normal behavioural functions.⁷³ Co-morbidity, the presence of more than one disorder also became the norm rather than the exception but attempts to study its impact have been complicated by the lack of consensus about how to define and measure the concept.⁷⁴

⁶⁸ ICD-10 was endorsed by the Forty-third World Health Assembly in May 1990 and came into use in WHO Member States as from 1994.

⁶⁹ Gary Greenberg, *The Book Of Woe: The DSV And The Unmaking Of Psychiatry* (Scribe Publishers, 2013).

⁷⁰ Allen Frances, *Saving Normal: An Insider's Revolt Against Out-Of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life* (William Morrow 2013)

⁷¹ Ibid. See also Gary Greenberg, *The Book Of Woe: The DSV And The Unmaking Of Psychiatry* (Scribe Publishers, 2013).

⁷² Nick Haslam, 'Categorical versus dimensional models of mental disorder: the taxometric evidence' (2003) 37 *Australian and New Zealand Journal of Psychiatry* 696, 696.

⁷³ Horwitz, above n 63.

⁷⁴ Jose M Valderas *et al.*, 'Defining Comorbidity: Implications for Understanding Health and Health Services' (2009) 7 *Annals of Family Medicine* 357.

It has also been widely accepted that the addition of many ‘new’ diagnostic guidelines to the DSM-III in 1980 ‘unintentionally positioned psychopharmacology on a growth trajectory’⁷⁵ which has not slowed.

The D.S.M. is the offspring of odd bedfellows: the medical industry, with its focus on germs and other biochemical causes of disease, and psychoanalysis, the now-largely-discredited discipline that attributes our psychological suffering to our individual and collective history.⁷⁶

Despite these criticisms, both systems have been adopted by key Australian agencies. The Australian Bureau of Statistics used an adapted version of the ICD-10 for its surveys including the 2001 National Health Survey.⁷⁷ The classification systems were also referenced in the Third National Mental Health Plan 2003–08 although they were omitted from mention in the Fourth National Mental Health Plan 2009–14. This omission suggests a change in policy focus reflected in a number of recent national mental health policies that has seen a distancing from the once favoured biomedical paradigm of previous plans toward the placement of more emphasis on the psychosocial model which is discussed below.

3.5 Diagnosis or misdiagnosis?

There is much more scope for interpretation and dissent in psychiatry than in most other medical fields due to the more rudimentary knowledge base, and the greater distance from clinical realities.⁷⁸ It is axiomatic that psychiatrists often disagree on a diagnosis, and if not the diagnosis, on the treatment needed for the management of the symptoms.⁷⁹ An example of this type of polar disagreement between mental health professionals became apparent when five men who were experiencing mental illness died in Tasmania’s 260 bed prison within a five month period in 1999/2000. The deaths prompted a public outcry that resulted in two separate inquiries: a Death

⁷⁵ Rick Mayes and Allan V Horwitz, ‘DSM-III and the Revolution in the Classification of Mental Illness’ (2005) 41 *Journal of the History of the Behavioral Sciences* 249, 266.

⁷⁶ Gary Greenberg, ‘Not Diseases, but Categories of Suffering’, *The New York Times* (online), 29 January 2012 <http://www.nytimes.com/2012/01/30/opinion/the-dsms-troubled-revision.html?_r=2&ref=opinion>.

⁷⁷ Australian Bureau of Statistics (ABS), National Health Survey: Summary of Results, (Report, No 4364.0, Canberra, 2001).

⁷⁸ Michele T Pathé and Paul E Mullen, ‘The Dangerousness of the DSM-III-R’ (1993) 1 *Journal of Law and Medicine* 47.

⁷⁹ The *New York Times* published an article by Benedict Carey on 11 November, 2006 titled What’s Wrong With a Child? Psychiatrists Often Disagree in which he referred to a 13 year old boy who had had 13 different the diagnoses. His first diagnosis was depression. He was aged 7. ‘Each diagnosis was accompanied by a different regimen of drug treatments.’

in Custody inquest conducted by the state coroner and another inquiry initiated by the Tasmanian Ombudsman.⁸⁰

The issue of medical diagnosis and misdiagnosis was a prominent factor in the subsequent findings of the mens' deaths and led to the coroner's recommendation that a system of peer review of psychiatric decisions be implemented.⁸¹

...the diagnosis by Dr. Pargiter on the 18/8/99 of a major depressive disorder which Dr. Jager disagreed with 3 days later without allowing for any period of observation by him⁸²... Dr Jager agreed he read Fabian's forensic file which included the reports of the psychiatrists and psychiatric registrar all of whom had previously diagnosed Fabian as suffering from schizophrenia. His view however was that Fabian was a severely personality disordered individual with an anti-social and narcissistic profile. His condition was likely to be a psychopathic personality disorder and unlikely to be schizophrenia.⁸³ ...While Dr. Sale disagreed with Dr. Jager's diagnosis...he said that the treatment Dr.Jager was giving Fabian....the anti-psychotic drugs, would have been what he would have done anyway.⁸⁴

Psychiatrists use the diagnostic classification lists to aggregate symptoms, manifestations and behaviours deemed abnormal or dysfunctional then subjectively afford different value weights and rankings to, too often, arrive at inconsistent, uncertain, unprovable, unreliable and inaccurate diagnoses.⁸⁵ The strategy of constructing standardised definitions of designated behavioural indicators to aid psychiatrists to make appropriate and consistent diagnoses has not been as successful as hoped.⁸⁶ Suggested causes for this include the view that severe

⁸⁰ Ombudsman Tasmania, 'Report on an Inquiry Into Risdon Prison: Risdon Prison Hospital & Forensic Mental Health Services', volume 1, June 2001.

⁸¹ Recommendation 26, Magistrates Court Tasmania, 'Findings Deaths in Custody Inquest' (Inquest Report, Magistrates Court Tasmania, 26 March 2001)
<http://www.justice.tas.gov.au/__data/assets/pdf_file/0014/18050/Findings_Deaths_in_Custody_inquest.pdf>.

⁸² Ibid, 140.

⁸³ Ibid.

⁸⁴ Ibid, 141.

⁸⁵ Marlene Busko, *Adults Admitted to a Mood-Disorder Clinic Are Often Misdiagnosed*.
<<http://www.medscape.com/viewarticle/582125>>.

⁸⁶ Aleen Frances, 'The Forensic Risks of DSM-V and How to Avoid Them' (2010) 38 *Journal of the American Academy of Psychiatry and the Law* 11. See also Allen Frances, 'PTSD, DSM-5, and Forensic Misuse', *Psychiatric Times* (online), 30 September 2011

<<http://www.psychiatristimes.com/blog/couchincrisis/content/article/10168/1959645>>. 'In preparing DSM-IV, we worked hard to avoid causing confusion in forensic settings. Realizing that lawyers read documents in their own special way, we had a panel of forensic psychiatrists go over every word to reduce the risks that DSM IV could be misused in the courts. They did an excellent job, but all of us missed one seemingly small mistake—the substitution of an "or" for an "and" in the paraphilia section that lead to serious misunderstandings and the questionably constitutional preventive psychiatric detention of sexual offenders.'

mental disorders may exist on a continuum rather than as discrete binary possibilities and clinical entities,⁸⁷ and the differences in the ways that clinicians account for the social context of behavioural symptoms.⁸⁸

Psychiatrists can also differ on what symptoms are necessary to trigger a particular diagnosis. For example, some psychiatrists will diagnose every person experiencing a mood disorder as 'Bipolar'. A requisite symptom of Bipolar is a manic episode which involves a distinct period of abnormal, irritable moods, characterised by inflated self-esteem, sleeplessness and other traits. When 'mania' is not present, some psychiatrists will assume that it has occurred, but the person was unaware, or that it will occur at some point in the future, so make the Bipolar diagnosis. On the other hand, many patients who do have Bipolar but who have not experienced a manic episode are initially diagnosed and treated for major depression.

Many patients carry each of the diagnoses of Schizophrenia, Major Depression, Bipolar illness, and Schizoaffective Disorder at some points in their lives ... A recent review of the case of a woman who had committed suicide found that her psychiatrist had diagnosed her with all of these disorders within the past year. It's a rare patient who carries the same psychiatric diagnosis throughout their lifetime...Our field's inability to agree on what disorder an individual actually suffers from is held up by some as confirmation of their belief that psychiatry is just a bunch of pseudoscience at best or, at worst, a profit-driven business.⁸⁹

The results of a 2000 Bi Polar study by the American Psychiatric Association that followed up an earlier 1992 study reported that:

Over one third of respondents sought professional help within 1 year of the onset of symptoms. Unfortunately, 69% were misdiagnosed, with the most frequent misdiagnosis being unipolar depression. Those who were misdiagnosed consulted a mean of 4 physicians prior to receiving the correct

⁸⁷ John Cloud, 'The DSM: How Psychiatrists Redefine 'Disordered'', *Time* (online), 13 February 2010 <<http://www.time.com/time/health/article/0,8599,1964196,00>>.

⁸⁸ Stuart A Kirk and Derek K Hsieh, 'Diagnostic Consistency in Assessing Conduct Disorder: An Experiment on the Effect of Social Context' (2004) 74 *American Journal of Orthopsychiatry* 43, 53.

⁸⁹ Kevin Turnquist, *Problems with Psychiatric Diagnosis*, Readings in Humanistic Psychiatry <<http://kevinturnquist.org/problemsindiagnosis.php>>.

diagnosis. Over one third waited 10 years or more before receiving an accurate diagnosis.⁹⁰

The researchers expressed their concern that in 2000, psychiatrists were still misdiagnosing at the same high rates that had been occurring in 1992 while the numbers of family physicians misdiagnosing had significantly increased during the intervening period.

The high levels of misdiagnosis in psychiatry may be a function of symptom overlap. For example, Bipolar disorder was often misdiagnosed as schizophrenia because psychosis was more commonly associated with schizophrenia. A study of 100 patients with a primary diagnosis of major depression or Bipolar disorder found that 26% actually had an anxiety disorder, a thought disorder (schizoaffective disorder), or a personality disorder.⁹¹ Another study that examined psychiatric misdiagnoses in patients with chronic fatigue syndrome found that doctors often mentioned symptoms consistent with a depressive or anxiety disorder but failed to make a formal diagnosis. This failure may have been due to a general reluctance to ‘label’ a patient with a stigmatised diagnosis.⁹²

3.6 A diagnostician’s tool box – a manual, guesses and Google⁹³

It is estimated that doctors carry 2 million facts in their head in order to fulfil their diagnostic role although with the rapid expansion in medical knowledge, even this may not be enough.⁹⁴ A recent Australian study suggested that in difficult diagnostic cases, it is often useful to ‘google for a diagnosis.’⁹⁵ The media wrongly reported that general practitioners were being urged to try diagnosis by Google because it offered a greater chance of diagnostic accuracy.⁹⁶ This misreporting may

⁹⁰ Robert M Hirschfeld, Lydia Lewis and Lana A Vornik, ‘Perceptions and impact of bipolar disorder: how far have we really come? Results of the national depressive and manic-depressive association 2000 survey of individuals with bipolar disorder’ (2003) 64 *Journal of Clinical Psychiatry* 161, 161.

⁹¹ Busko, above n 84.

⁹² Tara Lawn *et al.*, ‘Psychiatric misdiagnoses in patients with chronic fatigue syndrome’ (2010) 1 *Journal of the Royal Society of Medicine Short Reports* 28.

⁹³ Google is an internet search engine.

⁹⁴ Hangwi Tang and Jennifer Hwee Kwoon Ng, ‘Googling for a diagnosis—use of Google as a diagnostic aid: internet based study’ (2006) 333 *British Medical Journal* 1143, 1144.

⁹⁵ *Ibid.*

⁹⁶ Hawkes, N., Health Editor, *The Sunday Times*, November 10, 2006
<<http://www.timesonline.co.uk/article/0,,8122-2446250,00.html>>

be an indicator of the general attitude toward psychiatrists as witch doctors⁹⁷ and shrinks.⁹⁸ The incomprehensibility that is the mind is attractive to the mystique of tribal sorcery and shamanism, and ritualistic tools such as wands and runes, even Google, for arriving at accurate diagnoses of mental illness. David L. Rosenhan famously asked in 1973, 'If sanity and insanity exist, how shall we know them?'⁹⁹ To answer his question, he, and eight other pseudo patients (a psychology graduate student, three psychologists, a paediatrician, a psychiatrist, a painter, and a housewife) were admitted to 12 psychiatric hospitals across the United States of America. After their admission, the pseudo patients behaved on the wards as they would normally behave. They were paragons of cooperation and compliance, and 'spoke to patients and staff as they might ordinarily'.¹⁰⁰ The length of hospitalisation for the pseudo patients ranged from 7 days to 52 days, with an average stay of 19 days.¹⁰¹ Every pseudo patient was discharged with a diagnosis of schizophrenia in remission. It seemed that the circumstances of the environment had made the sane insane and ordinary behaviour deviant. Rosenhan concluded, 'we have known for a long time that diagnoses are often not useful or reliable, but we have nevertheless continued to use them.'¹⁰²

The question was raised in 2008 by the BBC's science and philosophy program Horizon¹⁰³ as to whether the reliability of mental disorder diagnoses has improved since Rosenhan's provocative experiment forty years earlier. The program set out to answer this question in a two part documentary, *How Mad Are You?*¹⁰⁴ Ten volunteers, five of whom had a diagnosed mental illness, were brought together for

⁹⁷ E Fuller Torrey, *Witchdoctors and Psychiatrists: The Common Roots of Psychotherapy and Its Future* (Harper & Row, 1986). The author examines the similar techniques used by witch doctors and psychiatrists which he considers far outweigh any differences that exist.

⁹⁸ 'Shrink' likely originated from a commingling of the two words "head shrink" and the single word "headshrinker," indicating that it likely originated as a disparaging reference comparing the process of psychotherapy to primitive tribal practices of shrinking the heads of enemies. Reportedly, "shrink" was first used in literature by Thomas Pynchon in his book *The Crying of Lot 49* published in 1966. Retrieved from Dr Ron Sterling's website DearShrink.com. <<http://www.dearshrink.com/shrink.htm>>

⁹⁹ David L Rosenhan, 'On Being Sane in Insane Places' (1973) 179 *Science* 250, 250.

¹⁰⁰ Ibid 252.

¹⁰¹ Rosenhan, above n 98, '252.

¹⁰² Ibid 257.

¹⁰³ Horizon's original mission statement, broadcast on its first ever programme, reads: "The aim of Horizon is to provide a platform from which some of the world's greatest scientists and philosophers can communicate their curiosity, observations and reflections and infuse into our common knowledge their changing views of the universe. We shall do this by presenting science not as a series of isolated discoveries but as a continuing growth of thought, a philosophy which is an essential part of twentieth century culture." BBC Press Office, *BBC TWO's Horizon* (19 August 2004) BBC

<http://www.bbc.co.uk/pressoffice/pressreleases/stories/2004/08_august/19/horizon_facts.shtml>.

¹⁰⁴ The program was first shown in the UK on 11 and 18 November, 2008. SBS ran the show in Australia on 16 and 23 November, 2010

a week of intense observation by a panel of clinical experts who were to decide which of the five had one of six common mental disorders - Bipolar, schizophrenia, depression, social anxiety disorder, obsessive compulsive disorder (OCD), and anorexia.

The participants underwent a series of physical and mental challenges, psychiatric tests and interviews that were intended to expose the traits of a disorder. The psychological tests proved inconclusive and even created 'greater confusion'¹⁰⁵ for the experts. The panel correctly diagnosed the two participants with OCD and anorexia but incorrectly diagnosed three participants, two of whom had no history of mental illness. The panel were also required to choose one of the 10 who was definitely not a psychiatric service user. The experts again made an incorrect choice. Such a low diagnostic success rate appears to support Rosenhan's conclusions, although the results must be tempered by the fact that *Horizon* achieved its results within the limitations and gimmickry of popular factual television programming – reality genre.

Popular factual programs encourage public engagement with social and political issues through the experience of being entertained.¹⁰⁶ In engaging the audience in this way, too many restrictions were placed on the program's experts required to diagnose participants who were either experiencing a period of wellness or whose behaviours were being successfully managed by treatment. 'My worst fear was that... people would notice immediately that I have some sort of disorder. But the point...was to show people ... it is not easy for people to see that I have had mental health problems.'¹⁰⁷ Perhaps the producers used the Rosenhan experiment as the inspiration to explore the hypothesis that a mentally healthy person can be diagnosed as having a serious mental illness.

Possibly, the clearer intent was the portrayal of the guise of normalcy. In an endeavour to reduce stigma, and change attitudes, the program set out to demonstrate that people with significant mental health problems can live normal and undistinguished lives. Misdiagnosis was simply presented as a contributing

¹⁰⁵ Lesley Henderson, 'How mad are we?' (2008) 337 *British Medical Journal* a2641.

¹⁰⁶ Annette Hill, *Reality TV: Audiences and popular factual television* (Routledge, 2005) 171.

¹⁰⁷ Participant, *How Mad Are You?* (21 June 2010) Spotlight <<http://www.spotlightradio.net/listen/how-mad-are-you/>>.

factor in the blurred demarcation between normal and abnormal lifestyles.

Ancillary to this but certainly more concerning is whether the public will now be more worried that mental health experts are failing to diagnose individuals with serious mental disorders than interested in the possibility that a mentally healthy person might be incorrectly labelled with a serious mental disorder. Will this display of diagnostic guesswork played out in the medium of public entertainment contribute to an increase in the public's fear of people experiencing mental illness, and reinforce the stereotypes of them as being deceptive, secretive and manipulative?

Arriving at a correct mental health diagnosis is always a challenging exercise. A psychiatrist will usually offer up their 'best guess' based on their observation of a group of presenting symptoms. This diagnosis may be replaced by a later doctor's 'best guess' made from observing a different group of presenting symptoms in the person. In this way, it is not unusual for individuals to receive many different diagnoses over a lifetime, informed by psychiatrists observing only components of the overall pattern of behaviours categorised in the diagnostic manuals. Professor Sandifer's research on diagnosing schizophrenia found that more than a fifth of cases studied were not sufficiently clear to warrant a diagnosis but he suggested that professional pride and the pressure for statistical neatness emboldened psychiatrists to a diagnostic certainty that often the facts of a particular case did not support.¹⁰⁸

We have all learned our lessons rather well, and know the textbook definitions, but all might not agree that a particular patient has certain characteristics (and in a particular order of importance). The primary origin of our diagnostic differences lies, in my opinion, in the way different observers view the same patient.¹⁰⁹

The diagnostic manuals have become vital tools in psychiatric medicine. They provide the framework from which clinicians hang their intuitive and subjective psychiatric disorder attributions. Accurately diagnosing specific disorders causative to the person's state of mental illness is difficult, perhaps, even rarely possible, and from a medical perspective, may be unnecessary. As indicated by Dr Sales in his evidence to the Risdon Prison Inquiry, drugs are grouped together so that the

¹⁰⁸ Myron G Sandifer, 'Psychiatric Diagnosis: Cross-National Research Findings' (1972) 65 *Proceeding of the Royal Society of Medicine* 497, 500.

¹⁰⁹ *Ibid* 499.

benefits of a particular medication may span a number of different disorders while psychiatric treatment is generally a matter of trial and adjustment.

4. CONCLUSION

This chapter has shown that a ‘mental illness’ is a medical label to be found somewhere within the medical rhetoric of constructs contained within the DSM-IV Manual, and that psychiatry is largely a discipline of classification, observation and guesswork. There are no scientific tests such as x-rays or blood tests to prove the existence, or non-existence of a mental illness.¹¹⁰ The ‘only possible verification of the presence of mental disorder is by a consensus of those who have observed the actor's behaviour’¹¹¹ because, unlike measles, diabetes or hepatitis, mental illness is not really a ‘real disease’.¹¹² Yet once the label of ‘mentally ill’ is attached to an individual, the legal system is alerted that this person is, or may become at some point in an indeterminate future,¹¹³ irrational, unpredictable and dangerous. It is a social indicator of the person’s inferiority, vulnerability, and impaired decision-making capability and functioning capacity, which in turn justifies the imposition of restrictive and discriminatory laws, and biased decision-making that can impact harshly, and unfairly, on people experiencing a mental illness.

The psychiatrist is generally classed as the expert interpreter of a person’s life experiences and properly placed to intervene in the life of a person existing within the context of social abnormality – mentally diseased and ill –to help enable the person to overcome their pathology. The person’s perceived ‘suffering’, and their alleged inability to relieve themselves of their suffering without the intervention of the psychiatrist, and potentially, the coercive authority of the state, fixes the patient in the role of an inferior, helpless being, a role that is both a product and cause of the stigma associated with mental illness, a proposition fully discussed in Chapter Three.

¹¹⁰ Morse, above n 6.

¹¹¹ Ibid 607.

¹¹² Thomas Stephen Szasz, *The Myth of Mental illness* (Harper Collins, 2010). First published in 1974, this edition includes the Preface: Fifty Years After the Myth of Mental Illness.

¹¹³ *Mental Health Act 1996* (Tas) s 24. This section states that a person maybe involuntarily hospitalized in they have the appearance of a mental illness, and as a consequence there is a significant risk of harm to self or others but it fails to use time limiting terms such as imminent or immediate so that the harm can potentially occur at anytime in the future. There is also no definition for ‘harm’ although whatever it might mean, it includes ‘serious mental or physical deterioration’.

While all medical diagnoses are value laden, psychiatric diagnoses are quantitatively more so.¹¹⁴ Even though psychiatric opinions are commonly based on value-laden interpretations of classified sets of behaviours, unprovable diagnoses, and predictive assessments regarding future inappropriate behaviours, psychiatric evaluations are still regarded by the legal system as integral to decision-making when mental illness is a fact at issue.¹¹⁵ This is because there exists in the role of the psychiatrist, a superiority built upon their pseudoscientific knowledge of the socially unacceptable, abnormal behaviours of people experiencing a mental illness.

The health and legal institutions have joined together in a single, treatment control system which has thus far focused on regulating and managing abnormal social behaviours rather than on developing clear, consistent concepts and definitions that span the social sciences, medicine and the law. Until a concerted start is made on addressing the jurisdictional, conceptual and language inconsistencies across the various disciplines, people experiencing a mental illness will continue to be subjected to the biased, arbitrary and discriminatory application of the law:¹¹⁶

¹¹⁴ Nigel Eastman and Bella Starling, 'Mental disorder ethics: theory and empirical investigation' (2006) 32 *Journal of Medical Ethics* 94. See also K W M Fulford, 'Ten principles of values-based medicine' in Jennifer Radden (ed), *The Philosophy of Psychiatry* (Oxford University Press, 2004) 205.

¹¹⁵ Bernadette Dallaire, 'Civil commitment due to mental illness and dangerousness: the union of law and psychiatry within a treatment-control system' (2000) 22 *Sociology of Health & Illness* 679. See also David L Shapiro, *Forensic Psychological Assessment: An Integrative Approach* (Simon & Schuster, 1991).

¹¹⁶ Winick, above n 1, 555.

BIBLIOGRAPHY

A. Articles

Anderson-Watts, Rachael, 'Recognizing Our Dangerous Gifts: Applying the Social Model to Individuals with Mental Illness' (2008) 12 *Michigan State University Journal of Medicine and Law* 141.

Beumont Pierre, and Terry Carney, 'Can psychiatric terminology be translated into legal regulation? The anorexia nervosa example' (2004) *Australian and New Zealand Journal of Psychiatry* 819.

Brulde, Bengt, 'On defining "mental disorder": Purposes and conditions of adequacy' (2010) 31 *Theoretical Medicine and Bioethics* 19.

Cavadino, Michael, 'Mental illness and neo-Colonialism' (1991) 2 *Journal of Forensic Psychiatry* 295.

Dallaire, ¹ Bernadette, 'Civil commitment due to mental illness and dangerousness: the union of law and psychiatry within a treatment-control system' (2000) 22 *Sociology of Health & Illness* 679.

Eastman, Nigel, and Bella Starling, 'Mental disorder ethics: theory and empirical investigation' (2006) 32 *Journal of Medical Ethics* 94.

Frances, Aleen, 'The Forensic Risks of DSM-V and How to Avoid Them' (2010) 38 *Journal of the American Academy of Psychiatry and the Law* 11.

Guiduli, Karin A, 'Challenges for the mentally ill: the "threat to safety" defence standard and the use of psychotropic medication under title one of the Americans with Disabilities Act of 1980' (1996) 144 *University of Pennsylvania Law Review* 1149.

Haslam, Nick, 'Categorical versus dimensional models of mental disorder: the taxometric evidence' (2003) 37 *Australian and New Zealand Journal of Psychiatry* 696.

Havelka, Mladen, Jasminka Despot Lucanin, and Damir Lucanin, 'Biopsychosocial model-the integrated approach to health and disease' (2009) 33 *Collegium Antropologicum* 303.

Henderson, Lesley 'How mad are we?' (2008) 337 *British Medical Journal* a2641.

Henry Weihofen, 'The Law and the Mentally Ill: The Definition of Mental Illness' (1960) 21 *Ohio State Law Journal* 1.

Hirschfeld, Robert M, Lydia Lewis and Lana A Vornik, 'Perceptions and impact of bipolar disorder: how far have we really come? Results of the national depressive and manic-depressive association 2000 survey of individuals with bipolar disorder' (2003) 64 *Journal of Clinical Psychiatry* 161.

Johnson, Brad, 'Prophecy with Numbers: Prospective Punishment for Predictable Human Behaviour?' (2005) 7 *University of Technology Sydney Law Review* 117.

Kirk, Stuart A and Derek K Hsieh, 'Diagnostic Consistency in Assessing Conduct Disorder: An Experiment on the Effect of Social Context' (2004) 74 *American Journal of Orthopsychiatry* 43.

- Kirsch, Irving, *et al.*, 'Initial Severity and Antidepressant Benefits: A Meta-Analysis of Data Submitted to the Food and Drug Administration' (2008) 5 *Public Library of Science Medicine* 0260.
- Lawn, Tara *et al.*, 'Psychiatric misdiagnoses in patients with chronic fatigue syndrome' (2010) 1 *Journal of the Royal Society of Medicine Short Reports* 28.
- Lester, Helen, and Jonathan Q Tritter, "'Listen to my madness': understanding the experiences of people with serious mental illness" (2005) 27 *Sociology of Health & Illness* 649.
- Aboraya, Ahmed, *et al.*, 'The Validity of Psychiatric Diagnosis Revisited: The Clinician's Guide to Improve the Validity of Psychiatric Diagnosis' (2005) 2 *Psychiatry* 48.
- Livermore, Joseph M, Carl P Malmquist, and Paul E Meehl, 'On the Justifications for Civil Commitment' (1968) 117 *University of Pennsylvania Law Review* 75.
- Mayes, Rick, and Allan V Horwitz, 'DSM-III and the Revolution in the Classification of Mental Illness' (2005) 41 *Journal of the History of the Behavioral Sciences* 249.
- Morse, Stephen J, 'Crazy Behavior, Morals and Science: An Analysis of Mental Health Law' (1978) 51 *Southern California Law Review* 527.
- Morse, Stephen J, 'Mental Disorder and Criminal Law' (2011) 101 *The Journal of Criminal Law & Criminology* 885.
- Pathé, Michele T, and Paul E Mullen, 'The Dangerousness of the DSM-III-R' (1993) 1 *Journal of Law and Medicine* 47.
- Richardson, Geneva , 'Balancing autonomy and risk: A failure of nerve in England and Wales' (2007) 30 *International Journal of Law and Psychiatry* 71.
- Rosenhan, David L, 'On Being Sane in Insane Places' (1973) 179 *Science* 250.
- Rosenman, Stephen , 'Mental Health Law: An Idea whose Time has Passed' (1994) 28 *Australian New Zealand Journal of Psychiatry* 560.
- Sandifer, Myron G, 'Psychiatric Diagnosis: Cross-National Research Findings' (1972) 65 *Proceeding of the Royal Society of Medicine* 497.
- Tang, Hangwi, and Jennifer Hwee Kwoon Ng, 'Googling for a diagnosis—use of Google as a diagnostic aid: internet based study' (2006) 333 *British Medical Journal* 1143.
- Valderas, Jose M, *et al.*, 'Defining Comorbidity: Implications for Understanding Health and Health Services' (2009) 7 *Annals of Family Medicine* 357.
- Winick, Bruce J, 'Ambiguities In The Legal Meaning And Significance Of Mental Illness' (1995) 1 *Psychology, Public Policy, and Law* 534.

B. Books

Bilton, Tony, *et al.*, *Introductory Sociology* (Palgrave Macmillan, 4th ed, 2002).

Diagnostic and Statistical Manual of Mental Disorders (DSM-III), (American Psychiatric Association, 3rd Edition, 1980).

Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R), (American Psychiatric Association, 3rd Edition, 1987).

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), (American Psychiatric Association, 4th Edition, 2000).

Diagnostic and Statistical Manual of Mental Disorders (DSM-V), (American Psychiatric Association, 5th Edition, 2013).

Eldergill, Anselm, *Mental Health Review Tribunals: Law and Practice* (Sweet & Maxwell 1997).

Frances, Allen, *Saving Normal: An Insider's Revolt Against Out-Of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life* (William Morrow, 2013).

Fulford, K W M, 'Ten principles of values-based medicine' in Jennifer Radden (ed), *The Philosophy of Psychiatry* (Oxford University Press, 2004).

Gostin, Lawrence, *Mental health services: law and practice* (Shaw & Sons, 1986).

Greenberg, Gary, *The Book Of Woe: The DSM And The Unmaking Of Psychiatry* (Scribe Publishers, 2013).

Hale, Brenda, *Mental Health Law* (Sweet & Maxwell, 5th ed, 2010).

Hill, Annette, *Reality TV: Audiences and popular factual television* (Routledge, 2005).

Horwitz, Allan V, *Creating Mental Illness* (The University of Chicago Press, 2002).

Millgram, E, *Practical Induction*, Harvard University Press, Cambridge, 1997.

O'Sullivan, John, *Mental Health and the Law* (The Law Book Company, 1981).

Parsons, Talcott, *The Social System* (Tavistock, 1952).

Pilgrim, David, and Anne Rogers, *A Sociology of Mental Health and Illness* (Open University Press, 1999).

Selby, Hugh M, (ed), *Tomorrows Law* (Federation Press, 1995).

Shapiro, David L, *Forensic Psychological Assessment: An Integrative Approach* (Simon & Schuster, 1991).

Slovenko, Ralph, *Psychiatry in Law, Law in Psychiatry* (Routledge, 2009).

Szasz, Thomas Stephen, *The Myth of Mental illness* (Harper Collins, 2010).

Torrey, E Fuller, *Witchdoctors and Psychiatrists: The Common Roots of Psychotherapy and Its Future* (Harper & Row, 1986).

Weisstub, David N, (ed.), *Research on Human Subjects: Ethics, Law, and Social Policy* (Pergamon, 1998).

C. Grey Literature -Research Papers, Reports, Submissions, Letters, Memos etc.

‘Findings Deaths in Custody Inquest’ (Inquest Report, Magistrates Court Tasmania, 26 March 2001)
<http://www.justice.tas.gov.au/__data/assets/pdf_file/0014/18050/Findings_Deaths_in_Custody_inquest.pdf>.

‘Fourth National Mental Health Plan 2009–14’ (Plan, Australian Health Ministers, 2009)
<[http://www.health.gov.au/internet/main/publishing.nsf/content/360EB322114EC906CA2576700014A817/\\$File/plan09v2.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/360EB322114EC906CA2576700014A817/$File/plan09v2.pdf)>.

‘ICD-10 Classification of Mental and Behavioural Disorders’ (Clinical descriptions and diagnostic guidelines, World Health Organisation, 2010).
<<http://www.who.int/classifications/icd/en/bluebook.pdf>>.

‘Mental health: a state of well-being’ (Report, World Health Organization, October 2011)
<http://www.who.int/features/factfiles/mental_health/en/index.html>.

‘National Health Survey: Summary of Results’ (Report, No 4364.0, Australian Bureau of Statistics, 2001).

‘Report on an Inquiry into Risdon Prison: Risdon Prison Hospital & Forensic Mental Health Services’, volume 1, (Report, Ombudsman Tasmania, June 2001).

‘Third National Mental Health Plan 2003-2008’ (Plan, Australian Health Ministers, July 2003).
<http://peu.unimelb.edu.au/__data/assets/pdf_file/0009/32310/national_mental_health_plan_20032008.pdf>.

Beresford, Peter, Mary Nettle, and Rebecca Perring, ‘Towards a social model of madness and distress? Exploring what service users say’ (Report, Joseph Rountree Foundation, 2010) <<http://www.jrf.org.uk/publications/social-model-madness-distress>>.

De La Cruz, Ralph, ‘Mental Health Funding at Risk’, *Florida Centre for Investigative Reporting* (online), 9 March 2011 <<http://fcir.org/2011/03/09/mental-health-funding-at-risk/>>.

Memorandum on Parts of the *Mental Health Act* 1983 (Memorandum, Department of Health and Welsh Office, revised 1998).

Moncrieff, Joanna, ‘Is Psychiatry for Sale: An examination of the influence of the pharmaceutical industry on academic and practical psychiatry’ (Maudsley Discussion Paper, Institute of Psychiatry, 2003)
<<http://www.critpsynet.freeuk.com/pharmaceuticalindustry.htm>>.

Pridmore, Saxby, *Download of Psychiatry Chapter 1, University of Tasmania EPrint*, p. 8.
<http://eprints.utas.edu.au/287/2/Chapter_1_Introduction_to_psychiatry%5B1%5D.pdf>.

D. Media and websites

‘When it comes to Depression, Serotonin Isn’t the Whole Story’, *shots Health News from npr*, transcript of radio discussion, 23 January 2012, 2010.
<<http://www.npr.org/templates/transcript/transcript.php?storyId=145525853>>.

Busko, Marlene, *Adults Admitted to a Mood-Disorder Clinic Are Often Misdiagnosed*.
<<http://www.medscape.com/viewarticle/582125>>.

Carey, Benedict, ‘What’s Wrong With a Child? Psychiatrists Often Disagree’, *New York Times*, 11 November, 2006.

<http://www.nytimes.com/2006/11/11/health/psychology/11kids.html?pagewanted=all&_r=0>

Cloud, John, 'The DSM: How Psychiatrists Redefine 'Disordered'' (*Time*, 13 February 2010 <<http://www.time.com/time/health/article/0,8599,1964196,00>>.

Frances, Allen 'PTSD, DSM-5, and Forensic Misuse' (*Psychiatric Times*, 30 September 2011) <http://www.psychiatrictimes.com/blog/couchincrisis/content/article/10168/1959645>>.

Greenberg, Gary, 'Not Diseases, but Categories of Suffering' (*The New York Times*, 29 January 2012) <http://www.nytimes.com/2012/01/30/opinion/the-dsms-troubled-revision.html?_r=2&ref=opinion>.

Lexapro <http://www.frx.com/pi/Lexapro_pi.pdf>.

Paxil <http://us.gsk.com/products/assets/us_paxil.pdf>.

Robertson, Dr Michael, Senior Consultant Psychiatrist, Centre for Values, Ethics & Law in Medicine, University of Sydney, *ABC Radio National* interview with Natasha Mitchell, 18 April, 2009 <https://whyweprotest.net/community/threads/abc-oz-interviews-cchrs-thomas-szasz.38097/>.

Sterling, Dr Ron, DearShrink.com. <<http://www.dearshrink.com/shrink.htm>>

Turnquist, Kevin, Problems with Psychiatric Diagnosis, *Readings in Humanistic Psychiatry* <<http://kevinturnquist.org/problemsindiagnosis.php>>.

Eli Lilly Canada Inc, May 18, 2004, *Health Canada*, http://www.hc-sc.gc.ca/dhp-mps/medeff/advisories-avis/prof/_2004/prozac_hpc-cps-eng.php.

BBC TWO's Horizon (19 August, 2004)

<http://www.bbc.co.uk/pressoffice/pressreleases/stories/2004/08_august/19/horizon_facts.shtml>.

Hawkes, N., Health Editor, (*The Sunday Times*, November 10, 2006) <<http://www.timesonline.co.uk/article/0,,8122-2446250,00.html>>

E. Legislation

Mental Health Act 1959 (UK).

Mental Health Act 2013 (Tas).

Mental Health Act 1996 (WA).

Mental Health Act 2007 (NSW).

F. Cases

Buxton v Jayne [1960] 2 All ER 688.

Her Majesty the Queen and C.J.P. (Citation #2011 MBPC 62) September 16, 2011.

W v L [1974] QB711 688.

CHAPTER THREE

CONCEPTUALISING STIGMA: STEREOTYPES, PREJUDICE AND DISCRIMINATION

1. INTRODUCTION

A major premise of this thesis is that negative attitudes of law students regarding mental illness may be positively altered through their participation in therapeutic jurisprudence based clinical legal programs such as the Mental Health Tribunal Representation Scheme which is detailed in Chapter Seven. This premise rests on the Michael Perlin's proposition that the legal system stigmatises and discriminates against people who experience mental illness. It explores the prospect that if a positive system change is to occur, it may be propelled by the interest and commitment of law graduates disabused of myths and stereotypes. New lawyers who understand the barriers that people with a mental illness face in the community and particularly, when they confront the legal system. Lawyers who have acquired the attributes and skills to work both professionally and empathetically with this large group of vulnerable citizens and share the common goal of exposing, and eradicating the social acceptance of stigma and discrimination associated with mental illness in the law.

Chapter One examined the failure of the public health paradigms and policies to provide the law with clear and consistent guidance in decision-making matters in which mental illness is a factor. Chapter Two discussed the reliance of the law on the biomedical model and the diagnostic and social labelling of a person who experiences a mental illness as someone who is abnormal, different, disabled, and dysfunctional, and someone who carries with them the potential to commit harm to others. This risk factor is often the determinant factor for decision-makers when mental illness is an issue. This can unfairly disadvantage the individual, a situation that is evident in the family law parenting order matters discussed in Chapter Six but is as equally apparent upon examination of other aspects of law in which mental

illness is a factor such as criminal law, sentencing, child protection, guardianship and administration and legislative drafting.

This chapter is important to the thesis because it examines the phenomenon that is stigma. Stigma is a multi-faceted societal construct that involves attitudes, feelings and behaviours¹ and is best understood by examining the terms of its components; stereotypes, prejudice and discrimination, and the interconnectedness between the three.² Stigma associated with mental illness is a crucial phenomenon because while tolerance for other stigmatised groups has grown, for the people who experience mental illness, it persists to the extent that their castigation is socially acceptable.³ Stigma exists against even the mildest forms of mental illness.⁴ It is pervasive, pernicious and resistant to change.⁵ A valuable, if not indeed, a necessary first step to designing effective social and legal interventions to reduce stigma and decrease discrimination, particularly in the legal system which is discussed in more detail in the following chapters, is to identify and appreciate the theories that explain the processes that drive stigma.⁶

For this reason, this chapter presents a predominantly social science style discussion. It explores the theories of devaluing human characteristics through labelling, stereotyping, prejudice and discrimination which exist within the context of social power, and perpetuate within an environment of social inequality. The stigmatisation process distinguishes human differences which are linked to undesirable characteristics. These perceived differences are then exaggerated through the use of stereotypes that identify and label individuals and whole groups as inferior and dysfunctional, which in turn justify society's prejudicial and discriminatory responses to the exaggerated differences. Stereotypes provide the structure for predetermined negative attitudes; the cognitive and affective responses

¹ David L Penn and James Martin, 'The Stigma of Severe Mental Illness: Some Potential solutions for a Recalcitrant Problem' (1998) 69 *Psychiatric Quarterly* 235.

² Patrick W Corrigan and Amy C Watson, 'Understanding the impact of stigma on people with mental illness' (2002) 1 *World Psychiatry* 16, 16.

³ Andrea Stier and Stephen P Hinshaw, 'Explicit and Implicit Stigma Against Individuals With Mental Illness' (2007) 42 *Australian Psychologist* 106.

⁴ Stephen P Hinshaw and Andrea Stier, 'Stigma as Related to Mental Disorders' (2008) 4 *Annual Review of Clinical Psychology* 367.

⁵ Heather Stuart, 'Fighting Stigma caused by mental disorders: past perspective, present activities, and future directions' (2008) 7 *World Psychiatry* 185.

⁶ Corrigan and Watson, above n 2, 16.

that occur when negative attitudes are endorsed; and the behavioural actions prompted by prejudiced attitudes.

This chapter discusses the social theories that underlie, and offer explanation for these prejudicial attitudes and discriminatory practices although a complicating factor in the discussion is the sheer number and diversity of stigma theories and classifications. Accordingly, the chapter reviews only the seminal and most influential literature, commencing with Erving Goffman's classic devaluation and dehumanisation theory.⁷ It examines later theories that built on Goffman's theoretical foundation, in particular, Corrigan's theory of structural discrimination⁸ which is generally considered to be the most egregious form of indirect discrimination because of the pervasive impact that society's basic institutions have on people's lives.⁹ Common within all the theories, however, is reference to the implicit tension that exists between the individually focused psychomedical model and the sociological stigma as a mechanism of social control model.¹⁰

Chapter Three discusses the factors that led to deinstitutionalisation that in turn generated a social need to measure the public stigma associated with mental illness. The concept of stigma is not a recent creation but its traditional, historical theological and moral cause beliefs have been almost entirely supplanted by the post-industrial, post-enlightenment, 'medical model' which approaches mental illness as a disease, or a disease-like condition that produces abnormal behaviours that can, and should be, treated by medical professionals through somatic means.¹¹ This belief is a product of western medicine's idealisation that the body can be objectified and controlled, and its associated conviction that the failure to control abnormal behaviours must be ascribed to the diseased individual.¹² By applying the medical model to mental illness, the person is defined by the diagnostic label that

⁷ Erving Goffman was a sociologist prominent for his analyses of human interaction. He relied less on formal scientific method than on observation to explain contemporary life.

⁸ Corrigan and Watson, above n 2, 16.

⁹ John Rawls, *A Theory of Justice* (Harvard University Press, 1971).

¹⁰ Kristine Harris, 'Pride and Prejudice – Identity and stigma in leprosy work' (2011) 82 *Leprosy Review* 135.

¹¹ David Zigmond, 'The Medical Model—its Limitations and Alternatives' (2011) L1 *Physical Culture and Sport Studies and Research* 6 <<http://www.marco-learning.com/pages/david-zigmond/medical-model.htm>>.

¹² Jayne Clapton and Jennifer Fitzgerald, 'The History of Disability: A History of 'Otherness'' *New Renaissance News* (online), 1997 <<http://www.ru.org/human-rights/the-history-of-disability-a-history-of-otherness.html>>.

medically and socially signposts their past, present, and increasingly for the benefit of the legal system, predicted behaviours.¹³

Stigma is entrenched within society's institutions, including the legal system which despite its foundational principles of fairness and equality, is far from immune from the stereotypes, prejudices and discrimination associated with mental illness.¹⁴

According to Perlin, the legal system is largely blind to the hidden prejudices that sustain and perpetuate biased legal decision-making, and discriminatory practices that often deny dignity, respect and fairness to parties experiencing a mental illness.¹⁵ The law's stigmatic response emanates from a variety of misconceived and erroneous beliefs regarding mental illness such as psychiatric experts can accurately identify and measure dangerousness; the predictions of experts have a scientific foundation; the person with a mental illness is dangerous, lacks credibility, is unpredictable and should be feared; they are also childlike so must be protected; they need to be controlled because they are weak, irresponsible, and sometimes even blameworthy for their condition; they lack the capacity to show love or affection and so do not make good parents; they are presumptively incompetent; and they are unable to make autonomous life decisions particularly, when it involves their own medical care and treatment.¹⁶

The institutional embeddedness of stigma ensures that the inferior 'them' can be identified as people who should be intimidated, humiliated, coerced, restricted, avoided and segregated by the powerful 'us', a role traditionally performed by the law and its actors. Chapter Four will discuss the usefulness of the tool of law in challenging social stigma, particularly through anti-discrimination legislation but the law can also create and perpetuate stigma and discriminatory legal system practices.¹⁷ If a positive cultural shift is to occur in the legal system that results in reduced stigma and decreased discrimination, it will first require an understanding

¹³ Thomas H Richardson, 'Conceptual and Methodological Challenges in Examining the Relationship between Mental Illness and Violent Behaviour and Crime' (2009) *Internet Journal of Criminology* 1. See also Heather Stuart, 'Violence and mental illness: an overview' (2003) 2 *World Psychiatry* 121. See also Barbara D Underwood, 'Law and the Crystal Ball: Predicting Behavior with Statistical Inference and Individualized Judgment' (1979) 88 *Yale Law Journal* 1408.

¹⁴ Michael Perlin, *The Hidden Prejudice: Mental Disability on Trial* (American Psychological Association, 2000).

¹⁵ *Ibid.*

¹⁶ *Ibid* 43.

¹⁷ Scott Burris, 'Stigma and the law' (2006) 367 *The Lancet* 529.

and appreciation of the power and pervasiveness of stigma. This chapter is a contextual vehicle for getting to 'know the enemy'.

2. DEINSTITUTIONALISATION – A CAUSE FOR MEASURING STIGMA

Stigma is the consequence of prejudice and prejudice is detriment or damage, caused to a person by judgement or action in which his/her rights and dignity are disregarded. Prejudice leads to action, and this action is to stigmatise.¹⁸

Stigma is a major contributor to the burden of illness on societies as it influences case finding and treatment delivery, major factors in effective disease control.¹⁹ Stigma has a substantial impact on the experience of illness, help seeking, and treatment adherence. Identified with other stigma targets such as poverty, homelessness and sexual preferences, marginalised groups are more vulnerable to health issues, and health-related stigma, which contribute further to social disadvantage or discrimination.²⁰ The past sixty years has seen the study of stigma become an area of major research applied to a wide array of health related circumstances including leprosy,²¹ HIV/AIDS,²² cancer,²³ tuberculosis,²⁴ urinary incontinence,²⁵ cystic fibrosis,²⁶ obesity,²⁷ and mental illness.²⁸

The academic literature is replete with studies examining the psychological, sociological, structural, and interpersonal forces that create, support and maintain

¹⁸ Juan J Lopez-Ibor, 'The power of stigma' (2002) 1 *World Psychiatry* 23.

¹⁹ Mitchell Weiss, Jayashree Ramakrishna and Daryl Somma, 'Health-related stigma: Rethinking concepts and interventions' (2006) 11 *Psychology, Health & Medicine* 277.

²⁰ Ibid.

²¹ Opala, J., Boillot, F., (1996) Leprosy among the Iimba: Illness and healing in the context of world view, 42 *Social Science and Medicine* 3. See also Kristine Harris, 'Pride and Prejudice – Identity and stigma in leprosy work' (2011) 82 *Leprosy Review* 135.

²² Lynne Duffy, 'Suffering, shame, and silence: The stigma of HIV/AIDS' (2005) 16 *Journal of the Association of Nurses in AIDS care* 13.

²³ Sophie Lebel and Gerald M Devins, 'Stigma in cancer patients whose behavior may have contributed to their disease' (2008) 4 *Future Oncology* 717.

²⁴ Jean Macq *et al.*, (2006) Assessing the stigma of tuberculosis, 11 *Psychology, Health and Medicine* 3, pp.346-352

²⁵ Kathleen Sheldon and Linda Caldwell, 'Urinary incontinence in women: Implications for therapeutic recreation' (1994) 28 *Therapeutic Recreation Journal* 203.

²⁶ Kendea Nicole Oliver, Perceived Stigma and Self-disclosure in Adolescents and Adults Living with Cystic Fibrosis: Measuring the Impact on Psychological and Physical Health, Degree for Master of Arts in Psychology Thesis, Ohio State University, 2011.

<https://etd.ohiolink.edu/ap:0:0:APPLICATION_PROCESS=DOWNLOAD_ETD_SUB_DOC_ACCNUM:::F1501_ID:osu1307639721,inline>

²⁷ Lynne MacLean *et al.*, 'Obesity, stigma and public health planning' 24 *Health Promotion International* 88.

²⁸ Corrigan and Watson, above n 2. See also Jo C Phelan and Bruce Link, 'Conceptualizing Stigma' (2001) 27 *Annual Review of Sociology* 363.

stigma and define, describe, and measure the negative impact that stigma has on the social, vocational, and economic functioning of people who experience mental illness.²⁹ A few researchers have taken the extreme position that there is no stigma attached to mental illness at all³⁰ but for others, it is the term ‘stigma’ that is itself viewed as the problem as stigma is considered a conflation of cause and effect. ‘There’s stigma around the word stigma’.³¹ Most researchers consider stigmatisation to be a consequence of the dichotomy of the normalcy of ‘wellness’ and the abnormality of ‘illness’³² which is discussed in detail at Section 3.0.

Prior to the 1950s, historians and social scientists demonstrated little interest in the housing of ‘mental patients’.³³ Historically, mental illness had been regarded as a private matter that gave cause for shame and embarrassment, and as a topic of conversation, was inappropriate for public discussion.³⁴ For the public opinion analyst, the investigation of stigma associated with mental illness offered finite interest because of its limited public and political significance.³⁵ It would take the combination of the social impact of deinstitutionalisation (the process of replacing long stay psychiatric hospitals with community mental health services) policies; the appearance of the anti-psychiatry movement in the 1960s; and the igniting of public interest by Michel Foucault’s polemic, *Madness and Civilization* in 1964³⁶ to begin the demise of the scientific apathy for mental illness stigma research.³⁷

The concept of stigma as a component of the social impact of mental illness quickly gained popular attention amongst policy developers, social scientists and mental health professionals.³⁸ The standard albeit archaic dictionary definition of stigma as a mark or token of infamy, disgrace or reproach was supplanted in the vocabulary

²⁹ Neasa Martin, ‘From Discrimination to Social Inclusion, A review of the literature on antistigma initiatives in mental health’ (Literature Review, Queensland Alliance, 2009) < <http://www.mhcc.org.au/documents/From-discrimination-to-social-inclusion-Lit-review.pdf>>.

³⁰ Guido M Crocetti, Herzl R Spiro and Iradj Siassi, *Contemporary Attitudes towards Mental Illness* (University of Pittsburgh Press, 1974).

³¹ Meaghan Wray, ‘There’s stigma around the word stigma’ (2012) 139 *The Journal Queens University* <<http://queensjournal.ca/story/2012-04-05/news/theres-stigma-around-word-stigma/>>.

³² Steven James Bartlett, *Normality Does Not Equal Mental Health: The Need to Look Elsewhere for Standards of Good Psychological Health* (Praeger, 2011).

³³ Bill Forsythe and Joseph Melling (eds), *Insanity, Institutions and Society, 1800-1914: A social history of madness in comparative history* (Routledge, 1999).

³⁴ Andrew B Borinstein, ‘Public attitudes toward persons with mental illness’ (1992) 11 *Health Affairs* 186.

³⁵ Ibid.

³⁶ Michel Foucault, *History of Madness* (Jean Khalfa (ed)) (Jonathan Murphy and Jean Khalfa trans) (Routledge, 2006).

³⁷ Hinshaw and Stier, above n 4.

³⁸ Weiss, Ramakrishna and Somma, above n 19.

of public health culture, so that stigma became widely understood as a reference for adverse and exclusionary social processes experienced by members of marginalised and vulnerable groups. Greater emphasis was placed on achieving outcomes of community integration and social inclusion, and on the development of strategies that focused primarily on housing and employment. Although sociological interest appears to have plateaued in the 1990s, this was matched by a marked increase in the practical psychological and health studies of stigma.³⁹ Understanding and measuring stigma remains a priority interest for public opinion analysts.⁴⁰ Stigma research continues to be regarded as an important tool for identifying and ameliorating the social harms experienced by marginalised individuals who are brought into contact with the legal system.⁴¹

2.1 Community care to public vagrancy

Prior to the advent of the ‘enlightened’ asylum system in the 19th century,⁴² responsibility for the care and control of all but the dangerous and acutely disturbed rested primarily with families,⁴³ local parishes⁴⁴ and municipalities.⁴⁵ Family administered care typically meant cruel restraints,⁴⁶ incarceration in upstairs attics and downstairs cellars,⁴⁷ caging in pigpens, or being placed under the control of abusive servants.⁴⁸ If the family had financial means, the insane relative could be delivered into the care of untrained staff in private madhouses.⁴⁹ One such

³⁹ Ibid.

⁴⁰ Weiss, Ramakrishna and Somma, above n 19.

⁴¹ Juliana van Luoma *et al.*, ‘An investigation of stigma in individuals receiving treatment for substance abuse’ (2007) 32 *Addictive Behaviour* 1331.

⁴² Roy Porter, *Madness: A Brief History* (Oxford University Press, 2002).

⁴³ Andrew Scull, *The Most Solitary of Afflictions* (Yale University Press, 1993).

⁴⁴ In London prior to 1834, there were more than 90 separate parishes, many of them tiny with only a few hundred residents. Commencing in 1714 with the enactment of the first of various Acts of Parliament that governed the disposal and care of the mentally ill, parishes discharged their legal obligation by sending them to “pauper farms” situated on the outskirts of the city.

⁴⁵ Gerald N Grob, ‘Mental Health Policy in America: Myths and Realities’ (1992) 11 *Health Affairs* 7, 9. The US had a system of municipal almshouses.

⁴⁶ Edward Shorter, *History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (Wiley, 1997) 3.

⁴⁷ The incarceration of the mentally ill in private homes has been romantically conveyed through classic fiction. In the novel *Jane Eyre* by Charlotte Brontë, Rochester keeps his uncontrollably ‘mad’ wife Bertha secretly locked in the “attic”, or more correctly, a room on the third story of Thornfield House.

⁴⁸ Porter, above n 42.

⁴⁹ Grob, above n 45, 9. See also Elaine Murphy, ‘The Mad-house Keepers of East London’ (2001) 51 *History Today* 29.

madhouse was Bethlehem which was more commonly known as Bedlam.⁵⁰ All madhouses were generally places of neglect, restraint and mistreatment.⁵¹

Lunatic indigents were confined in gaols and work houses,⁵² and houses of correction and bridewells⁵³ although Shorter suggests that in 1826, the number of people that were actually detained in England was in fact minimal: 5,000 people in a country with a population of 10 million.⁵⁴ Myers suggests that in England and Wales during the 19th century, the number of insane workhouse inmates never fell much below 20 per cent of all known pauper lunatics.⁵⁵ While the cruel and inhumane treatment meted out to the lunatics detained in madhouses was newsworthy, it was particularly scandalous when the mistreated individual was a member of the aristocracy.⁵⁶ Legislative reform commonly followed when 'law was invoked as a sponge to mop up scandal wherever it should arise'.⁵⁷ Protective legislation including the *Workhouse Test Act* 1723 and the *Lunacy Act* 1845 were enacted to combat these flourishing abuses in private institutions, and by the late nineteenth century, private institutions had withered, to be replaced by public lunatic asylums.⁵⁸

2.2 The rise and fall of the asylum

The decline of the feudal age in the 16th century had caused the creation of a large, newly mobile underclass of poor which was lacking the traditional supports and protections of feudalism.⁵⁹ With the concurrence of the post reformation decline of the Church as an instrument of social welfare,⁶⁰ families increasingly abandoned

⁵⁰ Shorter, above n 46, 5.

⁵¹ Elizabeth M Varcarolis, *Foundations of Psychiatric Mental Health Nursing* (W.B. Saunders Company, 2005). See also Thomas S Szasz (ed), *The Age of Madness* (Routledge & Keegan Paul, 1975).

⁵² Allison Foerschner, 'The History of Mental Illness: From "Skull Drills" to "Happy Pills"' (2010) 2 *Student Pulse* 1.

⁵³ E D Myers, 'Workhouse or asylum: the nineteenth century battle for the care of the pauper insane' (1998) 22 *Psychiatric Bulletin* 575.

⁵⁴ Shorter, above n 46, 5.

⁵⁵ Myers, above n 53.

⁵⁶ Scull, above n 43.

⁵⁷ Clive Unsworth, 'Law and Lunacy in Psychiatry's 'Golden Age'' (1993) 13 *Oxford Journal of Legal Studies* 479, 500. See also Elaine Murphy, 'A mad house transformed: the lives and work of Charles James Beverly FRS (1788 - 1868) and John Warburton MD FRS (1795-1847)' (2004) 58 *Notes and Records of the Royal Society of London* 267.

⁵⁸ Elaine Murphy, 'A mad house transformed: the lives and work of Charles James Beverly FRS (1788 - 1868) and John Warburton MD FRS (1795-1847)' (2004) 58 *Notes and Records of the Royal Society of London* 267.

⁵⁹ Marvin Ventrell, 'Evolution Of The Dependency Component Of The Juvenile Court, 1899-1999' (1998) 49 *Juvenile and Family Court Journal* 1, 8.

⁶⁰ There are a number of excellent histories such as Clive Unsworth, 'Law and Lunacy in Psychiatry's 'Golden Age'' (1993) 13 *Oxford Journal of Legal Studies* 479. See also Henry R Rollin, 'Psychiatry at 2000, A bird's eye view' (2000) 24 *Psychiatric Bulletin* 11.

relatives to a life of begging and vagrancy.⁶¹ The ‘mentally ill swelled the streams of beggars that wandered the roads’.⁶² The immediate social impact of this new, impoverished class was a substantial increase in vagrancy, criminality and other types of behaviour contrary to peace and good order.⁶³ There was a growing public interest in social engineering. Lunatics were now classed as deviants, far removed from the attributes that were fundamental to the newly evolving industrial world: rational individualist qualities of self-control, predictability and responsibility. Society required that they be contained to a level that had previously been reserved for criminals.⁶⁴

This endemic social problem of lunatic vagrancy with its nuisance and violence committed on others generated strong public demand for state intervention in matters of mental illness. The *County Asylums Act* of 1808 authorised the establishment of refuge asylums for pauper criminally insane lunatics.⁶⁵ In 1842, Poor Law Commission, speaking in promotion of the asylum and against the workhouses stated that:

It must ... be remembered that with lunatics, the first object ought to be their cure, by means of proper medical treatment. This can only be obtained in a well-regulated Asylum: and therefore the detention of any curable lunatic in a workhouse is highly objectionable, on the score both of humanity and economy.⁶⁶

During the 18th and 19th centuries, these revolutionary ideas about asylum treatment with its benevolent concept of curing or alleviating the symptoms of mental illness through medical treatments and psychological interventions⁶⁷ were shifting the focus of mental health care from containment to treatment.⁶⁸ In 1796, the York Retreat was opened by the Quaker, William Tukes. This revolutionary institution followed a moral treatment/moral therapy model in which the use of physical

⁶¹ Foerschner, above 52.

⁶² Shorter, above n 46, 2.

⁶³ Ventrell, above n 59, 8.

⁶⁴ Leonard D Smith, ‘The County Asylum in the Mixed Economy of Care’ in Bill Forsythe and Joseph Melling (eds), *Insanity, Institutions and Society, 1800-1914* (Routledge, 2006) 33.

⁶⁵ Unsworth, above n 57.

⁶⁶ Poor Law Commission. Printed Directions on Lunatics in Workhouses 5.2.1842, quoted 1844 *Report Metropolitan Commissioners*, 95-96.

⁶⁷ Louis C Charland, ‘Benevolent theory: moral treatment at the York Retreat’ (2007) 18 *History of Psychiatry* 61.

⁶⁸ Shorter, above n 46.

restraints was minimised and improvements in the patients behaviour was sought through appeal to their ‘moral capacities’.⁶⁹

The American reformer Dorothea Dix, having forged links with the English Quakers, was thoroughly influenced by moral therapy and ‘what could be accomplished by using it to effect a relief of symptoms, even if not a complete cure, for people with mental illness.’⁷⁰ Returning to the United States, Dix lobbied for moral therapy institutions to be made available for the care of the insane poor throughout the country.⁷¹ At a time when most people experiencing a mental illness were consigned to extremely overcrowded and unpleasant county-run almshouses, Dix proved extremely successful in getting state-based mental institutions built and funded.⁷²

Back in the United Kingdom, the enactment of the *Medical Registration Act* 1858 had brought with it the formal recognition of medicine as a credible profession. The developing discipline of psychiatry’s theories of mind function as a convincing basis for the treatment of mental illness also shared in this new medical practice credibility.⁷³ By the mid 19th century, the asylum model had become widely regarded as a symbol of enlightened and progressive mental health care that offered, for the first time, professional treatment and humane custodial care for chronic cases of mental illness.⁷⁴ Further, in 1867 the enactment of the *Metropolitan Poor Act* resulted in a physical and philosophical transition of individuals classified as ‘pauper lunatics’ across from workhouses into places of medical care.⁷⁵

In the Australian colonies, the asylum system was forced upon the administration early. Not having an established British workhouse system of pauper relief for ‘destitute lunatics’, colonists experiencing mental illness were sent to infirmaries, make-shift hospitals, or gaol.⁷⁶ The unrestrained growth in the convict and settler

⁶⁹ Cirotan Smark, ‘Dorothea Dix: A social researcher and reformer’ (Working Paper No 06/15, University of Wollongong Faculty of Business - Accounting & Finance, 2006) 7.

⁷⁰ Ibid 4.

⁷¹ Smark, above n 69, 4.

⁷² Ibid 9.

⁷³ It wasn’t until 1971 that the College of Psychiatrists came into being.

⁷⁴ By the 1930s nearly 80 percent the mental hospital beds in the US were occupied by chronic patients. Gerald N Grob, ‘Mental Health Policy in America: Myths And Realities’ (1992) 11 *Health Affairs* 7.

⁷⁵ Alistair E Sutherland Ritch, ‘*Sick, Aged and Infirm*’ Adults in *The New Birmingham Workhouse, 1852 – 1912* (Thesis for Masters of Philosophy Degree, University of Birmingham, 2009) <http://etheses.bham.ac.uk/846/1/Ritch10MPhil_A1a.pdf>.

⁷⁶ Penelope Hetherington, *Paupers, poor relief and poor houses in Western Australia, 1829 to 1910* (University of Western Australia Publishing, 2009).

population, however, quickly brought with it serious sociological problems. Prisoners who had completed their sentences or who had been pardoned, or who were emancipated were often unable, or incapable, of supporting themselves due to the limited opportunities available in the new colonies.⁷⁷ The colonies' loose systems of supervision and minimum restraints soon proved inadequate, prompting the establishment of secure institutions.⁷⁸

While the Lunacy Commissioners in the United Kingdom were highly critical of the workhouse system for pauper lunatics, they were also concerned about the lack of space in the asylums⁷⁹ and the diminishing confidence in the results of asylum treatment. They reconciled themselves to the fact that only the acute pauper insane should be admitted to the asylums and that all other lunatics were to be sent to the workhouses.⁸⁰ By the mid 19th century, asylum critics were claiming that the asylums were becoming human warehouses in which mental illness had become irreversible.⁸¹ They were 'places of detention for confined lunatics rather than hospitals for the cure of the insane'.⁸² The earlier optimism that insanity could be curatively treated in asylums had all but disappeared by the late 19th century.⁸³

By the 20th century, the asylum was 'perceived as the vestigial remnant of a bygone age'.⁸⁴ Asylums had become grim environments where people were shut away, out of sight and out of mind, and the lack of public interest and political neglect became the norm.⁸⁵ Decades of financial neglect exacerbated by the combined impact of the Great Depression of the 1930s and World War II caused the post war asylum to be associated with squalor and brutality. The pejoratively titled 'snake pits' of the 1950s were generally regarded as having limited therapeutic benefit.⁸⁶ Asylums had lost their social and medical legitimacy and had become little more than

⁷⁷ Cyril Joseph Cummins, *A History of Medical Administration in New South Wales 1788-1973* (NSW Health, 2nd ed, 2003) 34.

⁷⁸ Ibid.

⁷⁹ S W D Williams, 'Our Over-crowded Lunatic Asylums' (1872) 17 *British Journal of Psychiatry* 515.

⁸⁰ Myers, above n 53.

⁸¹ Sidney Bloch, *Understanding Troubled Minds: A Guide to Mental Illness and Its Treatment* (Melbourne University Publishing, 2nd ed, 2011).

⁸² Robert Boyd, 'Presidential address: The Care and Treatment of the Insane Poor' (1870) 17 *Journal of Mental Science* 315.

⁸³ Myers, above n 53.

⁸⁴ Grob, above 45, 8. See also Gerald N Grob, 'The Paradox of Deinstitutionalization' (1995) 32 *Society* 51.

⁸⁵ Bloch, above n 81.

⁸⁶ William G Rothstein, *Readings in American health care: current issues in socio-historical perspective* (University of Wisconsin Press, 1995) 283.

containment facilities providing often life-long, custodial care to the chronically mentally ill.⁸⁷

2.3 From containment to treatment

The arrival of the neuroleptic/antipsychotic drugs in the 1950s radically altered the way mental illness was treated. In 1949, the Australian psychiatrist John F. J. Cade recognised the beneficial effects of lithium as a mood stabiliser on manic-depressive disorder (Bipolar) patients.⁸⁸ When Chlorpromazine⁸⁹ was released in 1954, it led a pharmacotherapy revolution that had a similar impact in psychiatry as the discovery of penicillin had had in mainstream health care.⁹⁰ At the time, the prevailing treatments for schizophrenia were psychosurgery, electroconvulsive therapy, and insulin shock therapy.⁹¹ While the new psychotropic drugs could not cure serious mental illnesses in the same way that antibiotics proved effective against acute infectious diseases, importantly, the new psychotropic drugs could alleviate aberrant behaviours.

Warner suggests the European social psychiatry revolution was another significant factor occurring at the time that contributed toward deinstitutionalisation although he contends that the impact of social psychiatry is largely overlooked by American commentators who accord central importance to the role of drug therapy.⁹² He suggests that antipsychotic drugs were more effective for patients who were in inadequate care and treatment settings but was of less value when administered in settings designed for the patient's well-being.⁹³ However, the combination of the pharmaceutical and social psychiatry revolutions did result in millions of previously

⁸⁷ Grob, above n 45.

⁸⁸ Graham Burrows and John W Tiller, 'Cade's observation of the antimanic effect of lithium and early Australian research' (1999) 33 *Australian and New Zealand Journal of Psychiatry* 27.

⁸⁹ Chlorpromazine was marketed in the USA as Thorazine and in Europe and Australia as Largactil. Chlorpromazine was the first of many antipsychotic drugs developed which are used to block receptors in the brain's dopamine pathways. Adverse affects of antipsychotic drugs include lowered life expectancy, weight gain, tardive dyskinesia, diabetes, tardive akathisia, sexual dysfunction and tardive dysphrenia.

⁹⁰ Robert Whitaker, 'Anatomy of an Epidemic: Psychiatric Drugs and the Astonishing Rise of Mental Illness in America' (2005) 7 *Ethical Human Psychology and Psychiatry* 23, 23. See also Francisco López-Muñoz *et al.*, (2005) 'History of the discovery and clinical introduction of chlorpromazine' (2005) 17 *Annals of Clinical Psychiatry* 113.

⁹¹ Joel T Braslow, 'History and Evidence-Based Medicine: Lessons from the History of Somatic Treatments from the 1900s to the 1950s' (1999) 1 *Mental Health Services Research* 231.

⁹² Richard Warner, *Recovery from Schizophrenia: Psychiatry and Political Economy* (Brunner-Routledge, 1985).

⁹³ *Ibid* 86.

untreatable and clinically hopeless psychiatrically institutionalised patients being able to have their socially unacceptable behaviours effectively managed.

This ability to effectively manage socially inappropriate behaviours enabled many patients, often to their disadvantage, to be transferred across to the administratively less expensive, care homes system.⁹⁴ This system functioned with poorly paid and untrained staff in facilities where wards were locked, overcrowded and shabby; amenities, programs and services were deficient or absent; and the only treatment available was drugs.⁹⁵ In 2009, a Federal Court in the United States found that New York State had discriminated against thousands of people experiencing a mental illness by housing them within a system of privately run adult homes which had effectively replaced the state-run psychiatric hospitals but were themselves little more than institutions.⁹⁶ But as un-therapeutic and forlorn as the homes system was, many commentators at the time believed that the situation was far worse for ex-patients discharged into the community to live in isolation and fear, without adequate treatment and employment and shelter opportunities.⁹⁷ By the mid 1970s, however, the majority of western governments were committed to the policy of deinstitutionalisation and were preparing for the wholesale movement of patients into the general community in line with the principles of normalisation, a process essentially completed by the late 1990s.⁹⁸

2.4 Policy development

We as a Nation have long neglected the mentally ill⁹⁹

The earliest deinstitutionalisation policies and objectives focused on moving the newly functioning patients out of state public psychiatric hospitals,¹⁰⁰ prompting criticism that ‘there was no planning before or during deinstitutionalization’¹⁰¹ and

⁹⁴ Ibid.

⁹⁵ Ibid.

⁹⁶ Disability Advocates, Inc v David A. Paterson, Case 1:03-cv-03209-NGG-MDG Document 341 Filed 09/08/09, per Justice Nicholas G. Garaufis.

⁹⁷ Ellen L Bassuk and Samuel Gerson, ‘Deinstitutionalization and mental health services’ (1978) 238 *Scientific American* 46. See Leona L Bachrach, ‘Deinstitutionalization of mental health services in rural areas’ (1977) 28 *Hospital and Community Psychiatry* 669.

⁹⁸ Margaret Tennant, ‘Disability in New Zealand: An historical survey’ (1996) 2 *New Zealand Journal of Disability Studies* 3.

⁹⁹ Remarks [of President John F. Kennedy] on Proposed Measures to Combat Mental Illness and Mental Retardation, PUB. PAPERS 137, 138 (Feb. 5, 1963).

¹⁰⁰ Chris Koyanagi and Justice David C Bazelon, ‘Learning From History: Deinstitutionalization of People with Mental Illness as Precursor to Long-Term Care Reform’ (Briefing Paper, Kaiser Commission, August 2007) 1.

¹⁰¹ John A Talbott, ‘Deinstitutionalization: Avoiding the Disasters of the Past (A reprint from *Hospital and Community Psychiatry*)’ (2004) 55 *Psychiatric Services* 1112.

warnings that nothing was being provided on the outside for the former mental hospital patients.¹⁰² These initial critics were dismissed as ‘impeding the triumph of the new social psychiatry’.¹⁰³ The focus of later policies did shift toward improving and expanding the range of available community services and supports as lessons had been learned from the experiences of the first wave of patients. Being able to effectively medicate former patients alone did not ensure their community acceptance and tenure.¹⁰⁴

The widespread closure of the large psychiatric institutions in the 1990s brought with it another shift in deinstitutionalisation policies.¹⁰⁵ This newest wave of discharged patients encountered the same conditions of poverty, homelessness, unemployment and social rejection as the patients in the previous rounds. This time governments responded by developing and implementing inclusionary public policies and programs and enacting anti-discrimination legislation to protect the rights of people experiencing mental illness to accommodation, employment and lifestyle. The United States enacted the Americans with Disabilities Act in 1990. Australia enacted the *Disability Discrimination Act* in 1992 and the United Kingdom enacted the *Disability Discrimination Act* in 1995.

2.5 The growth of stigma research

Critics of deinstitutionalisation have argued that it was a ‘most stunning public policy failure’¹⁰⁶ and ‘[i]t is now an axiom that deinstitutionalization caused the contemporary epidemic of homelessness for the mentally ill’.¹⁰⁷ Rothman suggests that while it was hardly debateable that deinstitutionalisation ‘failed to deliver appropriate services to ex-mental patients or other persons in need of them’, it is inappropriate to suggest that a process that reached its peak in the 1970s is the root cause of current homelessness. As has been shown in 2.1 and 2.2, people experiencing mental illness have historically been highly representative within the

¹⁰² Richard Lamb, ‘Deinstitutionalization and the homeless mentally ill’ (1984) 35 *Hospital & Community Psychiatry* 899.

¹⁰³ Robert Sommer and Humphry Osmond, ‘The Mentally Ill in the Eighties’ (1981) 10 *Journal of Orthomolecular Psychiatry* 193, 199.

¹⁰⁴ Koyanagi and Bazelon, above n 100, 1.

¹⁰⁵ Jeffrey Draine *et al.*, ‘Role of Social Disadvantage in Crime, Joblessness, and Homelessness Among Persons With Serious Mental Illness’ (2002) 53 *Psychiatry Services* 565.

¹⁰⁶ David Mechanic and David A Rochefort, ‘Deinstitutionalization: An Appraisal of Reform’ (1990) 16 *Annual Review of Sociology* 301, 302.

¹⁰⁷ Robert Weisberg, ‘Restorative Justice and the Danger of “Community”’ (2003) 42 *Utah Law Review* 343, 364.

homeless population.¹⁰⁸ Newly created problems such as the ‘revolving door’ phenomenon where patients are discharged from psychiatric hospitals only to be readmitted again within a short period are also blamed on deinstitutionalisation instead of insufficient community resources.¹⁰⁹

However, the social issues associated with deinstitutionalisation and the implementation of community-based mental health care has succeeded in propelling the issue of mental illness into public view. What had once been a private, ‘out of sight, out of mind’ topic became a visible community problem confronting an unprepared and concerned public that was reminiscent of the social movement of the pauper lunatics in the 17th and 18th centuries. The newly deinstitutionalised had become the newly homeless, the newly unemployed and the newly poor on urban landscapes world-wide.¹¹⁰ They also became the newly criminalised. ‘This resulted, in part, from the after-effects of deinstitutionalization, but more importantly from stigma, fear, anger and the misuse of the dangerousness concept’.¹¹¹ This unexpected, swift and largely unplanned process of deinstitutionalisation triggered an explosion of quantitative and qualitative research beginning in the early 1950s.¹¹²

Initially, mental health professionals wanted to measure the level of public acceptance toward recently discharged patients in need of accommodation, employment and community health care but for many other commentators, deinstitutionalisation represented a revolution of rights in mental health law that began with the exercise of the fundamental right to liberty.¹¹³ For others, the unplanned and reactionary process of deinstitutionalisation was seen as the first step down a pathway of unfairness, intolerance and ignorance.¹¹⁴ The media’s stigmatised reporting of the association of violence in the community with mental

¹⁰⁸ David Rothman, ‘The Rehabilitation of the Asylum’ (2000) *The American Prospect* <<http://prospect.org/article/rehabilitation-asylum>>.

¹⁰⁹ Rachel Merton and Jenna Bateman, ‘Social Inclusion: Its Importance to Mental Health’ (Research Report, Mental Health Coordinating Council, 2007).

¹¹⁰ Lamb, above n 102.

¹¹¹ John W Parry, *Criminal Mental Health and Disability Law, Evidence and Testimony: A Comprehensive Reference Manual for Lawyers, Judges and Criminal Justice Professionals* (American Bar Association, 2009) 22-23.

¹¹² Lamb, above n 102.

¹¹³ Mechanic and Rochefort, above n 106.

¹¹⁴ Mark J Mills and Bonnie D Cummins, ‘Deinstitutionalization Reconsidered’ (1982) 5 *International Journal of Law and Psychiatry* 271.

illness made the public increasingly fearful.¹¹⁵ The wealth of data collected over the past six decades has identified, measured, confirmed, and reconfirmed the fact that the public has held fast to negative attitudes and opinions regarding people who experience mental illness and that it is largely unwilling to accept any deviation away from established standards of normalcy. What deinstitutionalisation did succeed in doing was reveal the ‘elephant in the room’. Stigma was a phenomenon that had to be studied if effective strategies were to be developed to reduce its negative impact on the lives of people experiencing a mental illness.

3. STIGMA: BEING DIFFERENT BY BEING ‘ILL’

The origin of stigma is rooted deeply in the control mechanism of the law and punitive processes of ancient cultures wanting to indelibly identify miscreants as deviant participants in normal society.¹¹⁶ The concept of stigma arose from the Greco-Roman practice of tattooing delinquent slaves¹¹⁷ and criminals,¹¹⁸ usually on the face, with missives indicating status and offence. Herodas Bion described his freed slave father as having ‘not a face, but a narrative on his face, the mark of his master's harshness’.¹¹⁹ Plato ordained that ‘if anyone is caught committing sacrilege, if he be a slave or a stranger, let his offence be written on his face and his hands’.¹²⁰ The Romans adopted both the Greek practice and the Greek term used to describe the markings. This word has passed into present English language use as ‘stigma’. Its meaning, and the message it conveys are as widely understood today as they were in antiquity, although the stigmatising process has grown beyond the simplicity of imposing an identifying mark on a person’s body.

The stigmatised contemporary does not even need be aware of their discredited position in society, although research suggests that children within a stigmatised

¹¹⁵ Fuller E Torrey, ‘The Association of Stigma with Violence’ (2011) 168 *The American Journal of Psychiatry* 235.

¹¹⁶ ‘Cut off the hands of thieves, whether they are male or female, as punishment for what they have done’ *The Qur’an*, 5:38

¹¹⁷ A third century Hellenistic legal code clause states that masters may not ‘sell slaves for export, nor tattoo them’. The prohibition applied only to good slaves because another clause states that if a slave commits a crime, the injured party ‘shall give him not less than a hundred lashes of the whip and tattoo his forehead’.

¹¹⁸ W Mark Gustafson, ‘Inscripta in Fronte: Penal Tattooing in Late Antiquity’ (1997) 16 *Classical Antiquity* 79.

¹¹⁹ Christopher P Jones, ‘Stigma: Tattooing and Branding in Graeco-Roman Antiquity’ (1987) 77 *The Journal of Roman Studies* 139, 148.

¹²⁰ Plato, *The Laws of Plato*, (University of Chicago Press, 1980), P1., Leg. 854D. 59

group become aware at a very early age that they are discriminated against.¹²¹ The stigmatiser needs only to hold the erroneous belief that the stigmatised person is less worthy, less credible and less able than normal members of society.

Stigmatisers do, however, share common attributes such as feelings of antipathy, distrust and even pity toward the stigmatised person but importantly, they share the desire to subdue and control individuals who are different.¹²² For the stigmatised mental illness group, this is achieved primarily through legal interventions such as civil commitment, involuntary treatment, guardianship processes and in family law, the making of parenting orders, a subject discussed in Chapter Six.

3.1 Illness – a condition of difference

The socio-cultural concept of mental illness draws its meaning from the philosophical realm of metaphysical ontology¹²³ in which health, disease, wellness and illness exist in dialectical relationship, and although distinct, are neither mutually exclusive nor are they polar opposites.¹²⁴ The ontological wellness/illness model follows a process of identifying entities and grouping them together into categories based on their relationship similarities and differences. In this way, ‘ill’ and ‘healthy’ are grouped as a pair of contrasting, and in theory, mutually exclusive core concepts that are also inseparable because they are defined through each other’s existence.¹²⁵ They are human experiences of ‘actual or perceived function-dysfunction through the interaction of cognitive-affective dimensions arising out of intrapersonal, interpersonal, health-disease-related and extra-personal factors’,¹²⁶ situated in a set of overlapping circles in which either illness or wellness takes precedence at varying times in an individual’s life.

As the reality of the illness experience, and its personal and social context changes, the degree to which the illness is in the foreground or background of a person’s

¹²¹ Brenda Major and Laurie T O’Brien, ‘The Social Psychology Of Stigma’ (2005) 56 *Annual Review of Psychology* 393.

¹²² Nick Crossley, ‘R. D. Laing and the British anti-psychiatry movement’ (1999) 47 *Social Science & Medicine* 877. Anti-psychiatry emerged in the 1960s. Its leading exponents were Michel Foucault, R.D. Laing, Thomas Szasz and David Cooper who expressed numerous criticisms of psychiatry.

¹²³ Giovanni Stanghellini and Massimo Ballerini, ‘Values in Persons With Schizophrenia’ (2007) 33 *Schizophrenia Bulletin* 131.

¹²⁴ Louise Jensen and Marion Allen, ‘Wellness: The Dialectic of Illness’ (1993) 25 *Journal of Nursing Scholarship* 220.

¹²⁵ Jan Pols, *The Politics of Mental Illness: Myth and Power in the Work of Thomas S. Szasz* (Ebook) 122 <<http://janpols.net/>>.

¹²⁶ Jensen and Allen, above n 124.

world shifts.¹²⁷ The ill person undergoes an in principle, temporary change to their ontological and existential experiences. This change is negatively valued by society because being ill is categorised as an extraordinary, aberrant occurrence contrary to the normality that is identified as being healthy.¹²⁸ The negative impact of illness is not confined to the aberrant individual and the people around him or her but is also measured in terms of human suffering and economic loss that is experienced by the whole of society.¹²⁹

3.2 Illness – a social role

Pol¹³⁰ categorised illness as a trio of perspectives: phenomenological, behavioral, and biological.¹³¹ The first - phenomenological - is a discontinuation in a person's life founded in experiential change where being ill imposes feelings of passivity, powerlessness, loss of autonomy, dependency and loss of freedom, giving rise to feelings including fear, worry, resentment, anger, anxiety, suspicion and guilt.¹³² For the person experiencing a mental illness, the experiential change of being ill does not necessarily occur as a result of feeling physically unwell but may arise as a consequence of performing socially unacceptable behaviours, being assessed at being at risk of performing socially unacceptable behaviours, and psychiatric labelling. The prognosis is powerlessness, loss of autonomy, dependency, a loss of freedoms, state intervention, and the traumatic events associated with deprivation of liberty and forcible treatment. Experiential changes and negative value judgments result in all facets of suffering that is a necessary condition for being ill although suffering of itself is not a sufficient condition for being ill.¹³³

The second category - behavioral - is a discontinuity in the behaviour and functioning of the person who is being ill. The person will typically remain in bed, stay home from work, hand over their responsibilities such as the parenting of children to others; withdraw from social contact and generally, perform their normal

¹²⁷ Barbara L Paterson, 'The Shifting Perspectives Model of Chronic Illness' (2001) 33 *Journal of Nursing Scholarship* 21, 23.

¹²⁸ Pols, above n 125, 123.

¹²⁹ World Health Organisation, 'Investing in Mental Health' (Research Paper, World Health Organization, 2003) <http://www.who.int/mental_health/en/investing_in_mnh_final.pdf>.

¹³⁰ Pols, above n 125.

¹³¹ Ibid.

¹³² Ibid.

¹³³ Ibid.

behaviors and functions less well, as a certain degree of dysfunction is a necessary condition for being ill. Dysfunction alone, however, is not sufficient for being ill.¹³⁴

Taken from the biological angle, being ill is a discontinuity in living. In this context, illness is an ‘abnormality of form, structure, and/or function of some part, process or system of the individual.’¹³⁵ How is the person behaving differently when they are ill to the way they behaved when they were healthy, or to how healthy people behave in general? In this respect, abnormality is identified via a comparative measure against matters that are typified as either static-normal or ideal-normal. Abnormality of form, structure or function is a necessary condition for labeling a person as ill but abnormality alone is not a sufficient condition for being ill. Suffering, dysfunction and abnormality although independent of each other must all be present if a person is ill, and to qualify as an illness, the three factors must all be present at a certain level of severity.¹³⁶

If a person has an illness, then their social role as an ill person is typified by their right to be free from normal responsibilities and obligations at a measure that is dependent on the severity of their illness. It is a normal expectation that a person who is ill with a head cold might take a day off work but taking a month off work for the same severity of head cold is entirely unacceptable unless the severity of the illness increases in tandem with the right to be free from the responsibility to go to work i.e. head cold develops into bronchitis which in turn develops into pneumonia. It seems that the reverse is true with regard to a mental illness.

The stereotypical expectation is that a person experiencing a mental illness will be hospitalised, often for long periods of time, and often against their will. They may be forcibly required to undergo extreme regimes of psychotropic medication. They will be incapable, or deemed incapable of holding down jobs, maintaining relationships and sustaining stable accommodation. The state will statutorily free them, most often forcibly, from their responsibility to manage their financial affairs and their right to make autonomous decisions. It is the condition of their illness which marks them as socially different which excludes them from the normal society of the well. Stereotypically, they are expected to think, feel and act in

¹³⁴ Ibid.

¹³⁵ Ibid.

¹³⁶ Ibid.

certain ways. An example of this is the belief that parents who experience a mental illness are unable to have a 'meaningful' relationship with their children (see Chapter Six with regard to *Family Law Act 1975* parenting orders).

4. CONCEPTUALISING STIGMA

The French sociologist, Émile Durkheim was the first to examine stigma as a social phenomenon in 1895.¹³⁷ Since that time, social scientists have attempted to conceptualise the phenomenon with particular attention given to its study during the past few decades.¹³⁸ Despite the attention, the concept remains vaguely defined and an examination of the recent literature also exposes the expanse of definitional variability. Link and Phelan¹³⁹ suggest that there are two predominant reasons for this. First, the stigma concept has been applied to a vast range of unique circumstances which has resulted in researchers conceptualising stigma differently and secondly, that the investigation has been multidisciplinary with psychologists, sociologists, anthropologists, political scientists, and social geographers contributing to the research.

There is an overlap in interests across the disciplines and the approaches researchers have taken toward establishing a stigma concept appear to have come from different frames of reference and the placement of different emphases. Even researchers from the same discipline have different theoretical orientations. Some researchers have refrained altogether from providing an explicit definition and have turned instead to the dictionary for ordinary language definitions of stigma as a mark of shame, disgrace, infamy and reproach, or have turned toward related aspects of stigma such as rejection or stereotyping.¹⁴⁰ 'Stigma' has the same conceptual and definitional vagaries and inconsistencies as 'mental illness' and 'mental health' which relegates many studies of 'mental health stigma' to its consequences rather than to its causes.

¹³⁷ Émile Durkheim, *Rules of Sociological Method* (The Free Press, 1966) 68.

¹³⁸ Jo C Phelan and Bruce G Link, 'Conceptualizing Stigma' (2007) 27 *Annual Review of Sociology* 363.

Phelan and Link found that the number of articles in PsychInfo and Medline which mentioned the word stigma in their titles or abstracts dramatically increased between 1980 and 1999.

¹³⁹ Jo C Phelan and Bruce G Link, 'Conceptualizing Stigma' (2007) 27 *Annual Review of Sociology* 363.

¹⁴⁰ Ibid.

4.1 Devaluation theory

The classic starting point for defining the current notion of stigma is the work of Erving Goffman.¹⁴¹ Goffman's revisionist concept is based primarily on dyadic social interaction which holds as its central feature the tenet that social stigma is devaluation and dehumanisation. His defining account of what stigma means, which still underpins much of the current theoretical discussion and empirical research on stigma and stereotyping, entered social science prominence in 1963 with the publication of his seminal book, *Stigma: notes on the management of spoiled identity*.¹⁴²

Goffman focused his observations on attitudes toward individuals possessing attributes or characteristics that fall short of societal expectations. He glosses the term stigma as the situation in which an individual is disqualified from full social acceptance',¹⁴³ describing it as 'deeply discrediting within a particular social interaction',¹⁴⁴ and having the effect of reducing the stigmatised person in the stigmatiser's mind 'from a whole and usual person to a tainted, discounted one'.¹⁴⁵ He saw the stigmatised as victims of negative stereotypes that commonly elicit emotional reactions such as pity, anger, anxiety, or disgust.¹⁴⁶ They are people devalued solely based on their social identity and membership in a social group, to the extent that their full humanity is called into question.¹⁴⁷

In Goffman's view, mental illness is one of the most deeply discrediting and socially damaging of all stigmas.¹⁴⁸ He was highly critical of psychiatric hospitals. He considered them to be anti-therapeutic and believed that mental illness stigma was rooted in the very nature of psychiatric diagnosis and treatment.¹⁴⁹ Once the

¹⁴¹ Erving Goffman was a sociologist prominent for his analyses of human interaction. He relied less on formal scientific method than on observation to explain contemporary life.

¹⁴² Erving Goffman, *Stigma: notes on the management of spoiled identity* (Prentice-Hall, 1963). Goffman's book can be credited with conceptualizing stigma and creating a framework for the wealth of academic study during the past 47 years.

¹⁴³ Ibid 9.

¹⁴⁴ Ibid 3.

¹⁴⁵ Ibid.

¹⁴⁶ Bernard Werner, Raymond P Perry and Jamie Magnusson, 'An attributional analysis of reactions to stigmas' (1988) 55 *Journal of personality and social psychology* 738.

¹⁴⁷ Goffman, above n 142, 3.

¹⁴⁸ Stephan P Spitzer and Norman K Denzin (eds), *The mental patient* (McGraw-Hill 1968) Goffman, E., *The moral career of the mental patient*, pp. 226–234.

¹⁴⁹ Erving Goffman (ed), *Asylums: essays on the social situation of mental patients and other in-mates* (Anchor Books, 1961).

pre-patient¹⁵⁰ was convinced by their families or doctors that they that needed hospitalisation, as a hospital patient they would lose nearly all the relationships and rights that they had prior to their admission.¹⁵¹

Goffman's work succeeded in capturing widespread attention in what was a rapidly changing world trying to manage the legal, social and emotional consequences of civil libertarianism and human rights advocacy, and to fully understand and appreciate the increasing number of scientific developments such as the technological mapping of mental diagnoses. Faced with the exclusionary practices of a public unwilling to accept the new proximity of mental illness within its communities, policymakers and service providers embraced Goffman's innovative concept which seemed to give scientific and theoretical substantiation to that which was observed to be a practical truth.

4.2 Social structural aspects of stigma

For policymakers, and the researchers that guided them, unpacking stigma was the necessary first step in the development of processes and structures designed to change the public's negative attitudes. Optimistically, it was thought that by understanding the causes and effects of stigma, processes could be developed and laws enacted that would ultimately result in its eradication. The failure in significantly altering the public's negative attitudes toward mental illness suggests the naiveté of this simple linear approach to tackling the insidiousness that is stigma.¹⁵²

While Goffman's concept continues to influence public opinion analysis and public policy approaches toward countering stigma within population attitudes, his use of language and classification has become dated according to its critics.¹⁵³ The conceptual framework is inadequate and inappropriate for cross-cultural research and policymaking because his 'implications of a dominant *normal* run counter to

¹⁵⁰ According to Goffman, the moral patient's career has three principal phases the pre-patient, inpatient and past patient.

¹⁵¹ Goffman, above n 149.

¹⁵² Jo C Phelan *et al.*, 'Public conceptions of mental illness in 1950 and 1996: what is mental illness and is it to be feared' (2000) 41 *Journal of Health and Social Behavior* 188. By using comparable national surveys, the researchers found that despite an increased understanding of the causes of mental illness in 1996, stigma had increased. This was most recently confirmed still to be the case by E Fuller Torrey, 'Stigma and Violence: Isn't It Time to Connect the Dots?' (2011) 37 *Schizophrenia Bulletin* 892.

¹⁵³ Weiss, Ramakrishna and Somma, above n 19.

recognition and appreciation of multicultural societies and multiculturalism’.¹⁵⁴

Although his concept successfully shifted the formulation of stigma from symbols to social processes, it focused primarily on dyadic social interactions¹⁵⁵ and failed to give sufficient attention to the social structural aspects that form society as a whole.

The structure of society is defined by the organisation of its population according to established patterns of social interaction and it is these patterned social arrangements that determine in varying degrees, the actions of the individuals within the social structure.¹⁵⁶ On a macro level, social structures include social institutions which include the legal system. On a micro level, social structures are the standardised beliefs, values or norms that shape the behaviours of the relationship participants: lawyers, judges and legal system consumers.

Criticism of Goffman’s concept of stigma resulted in significant paradigm elaborations and refinements. Jones built on Goffman’s three categorisations with the proposition of six dimensions of stigma – concealability, course, disruptiveness, aesthetics, origin and peril.¹⁵⁷ The peril dimension is particularly important with regard to mental illness stigma because it marks a degree of difference that significantly engenders feelings of threat or danger in others. Elliot emphasised social interaction, defining stigma as a form of deviance where others judge a person as dangerous and unpredictable and lacking in the skills or attributes necessary to carry out legitimate social interaction.¹⁵⁸ It was this ‘illegitimacy’ that gave cause for the non-stigmatised group to ignore and exclude the stigmatised. The most productive area of stigma research in the past ten years has been in the area of internalised stigma with consumer/survivors¹⁵⁹ being surveyed for their personal experiences of mental illness stigma, prejudice and discrimination.¹⁶⁰

¹⁵⁴ Ibid, 279.

¹⁵⁵ Ibid.

¹⁵⁶ Douglas V Porpora, ‘Four Concepts of Social Structure’ (1989) 19 *Journal for the Theory of Social Behaviour* 195.

¹⁵⁷ Edward E Jones *et al.*, *Social Stigma: the Psychology of Marked to Relationships* (W.H. Freeman & Co., 1984).

¹⁵⁸ Gregory C Elliott, ‘Understanding stigma: dimensions of deviance and coping’ (1982) 3 *Deviant Behavior* 275.

¹⁵⁹ Nancy Tones, ‘The patient as a policy factor: a historical case study of the consumer/survivor movement in mental health’ (2006) 25 *Health Affairs* 720.

¹⁶⁰ Elaine Brohan *et al.*, ‘Experiences of mental illness stigma, prejudice and discrimination: a review of measures’ (2010) *BMC Health Services Research* <<http://www.biomedcentral.com/1472-6963/10/80>>. See also Matthias C Angermeyer and Herbert Matschinger, ‘The effect of personal experience with mental illness on the attitude toward individuals suffering from mental disorders’ (1996) 31 *Social Psychiatry and Psychiatric Epidemiology* 321. Also Beate Schulze and Matthias C Angermeyer, ‘Subjective experiences of stigma: A focus

Corrigan¹⁶¹ proposed a dual model in which the category of self stigma or internalised stigma¹⁶² is set alongside the category of public stigma. This is then broken down into three further elements: stereotypes, prejudice and discrimination. Thornicroft¹⁶³ revised Corrigan's definition by including problems of knowledge (ignorance or misinformation), problems of attitudes (prejudice) and problems of behaviour (discrimination) claiming that the 'combination of these three elements has a powerful force for social exclusion'.¹⁶⁴ Link and Phelan defined stigma as the convergence of four interrelated components within a power situation - (1) identification and labelling of human difference; (2) the association of those differences with undesirable characteristics; (3) a separation of the 'them' from 'us'; and (4) the experience of loss of status and discrimination by the 'them'.¹⁶⁵

Stigma as a whole consists of a number of interrelated components that include elements such as labelling, status loss, exclusion, discrimination, stereotyping and separation and each component is named 'stigma'. Stigma is also dependent on social, economic, and political power with power being essential to the social production of stigma. Power differences within the legal system are institutionalised, which is seen as unproblematic, but within this forum of established and acceptable power imbalances, mental illness stigma simply remains, unseen.

5. STEREOTYPES - EXAGGERATING DIFFERENCE

The major barriers for people experiencing a mental illness are attitudinal barriers, labelling, stereotypical thinking and ill-informed and inaccurate assumptions¹⁶⁶ that prevent individuals from participating fully in a society in which autonomy resides

group study of schizophrenic patients, their relatives and mental health professionals' (2003) 56 *Social Science & Medicine* 299. Also Otto F Wahl, 'Mental Health Consumers' Experience of Stigma' (1999) 25 *Schizophrenia Bulletin* 467.

¹⁶¹ Patrick W Corrigan, *On the Stigma of Mental Illness* (American Psychological Association, 2005). Also Patrick W Corrigan and Amy C Watson, 'The paradox of self-stigma and mental illness' (2002) 9 *Clinical Psychology, Science and Practice* 35.

¹⁶² Jennifer Boyd Ritsher, Poorni G Otolingam and Monica Grajales, 'Internalized stigma of mental illness: psychometric properties of a new measure' (2003) 121 *Psychiatry Research* 1.

¹⁶³ Graham Thornicroft *et al.*, 'Stigma: ignorance, prejudice or discrimination?' (2007) 190 *British Journal of Psychiatry* 192.

¹⁶⁴ Graham Thornicroft, 'Stigma and discrimination limit access to mental health care' (2008) 17 *Epidemiologia e Psichiatria Sociale* 14, 14.

¹⁶⁵ Link and Phelan, above n 138.

¹⁶⁶ Patrick W Corrigan, 'Mental health stigma as social attribution: Implications for research methods and attitude change' (2000) 7 *Clinical Psychology Science and Practice* 48.

with the individual who is able to discipline their emotions by rationality. Fuelled by ignorance, misinformation, fears and assumptions,¹⁶⁷ the stigmatised perception of the person experiencing a mental illness is that they are unable to structure their life within a framework of consistent normalcy, control their disordered, impulsive and maladaptive thoughts, or restrain their emotional disturbances. It is these stereotypical assumptions that form the core of the public's stigmatising attitudes.¹⁶⁸

Stereotypes are ubiquitous. They are not intrinsically bad and nor are they intrinsically good. They are components of communication that are present in a person's cognitive repertoire, providing an efficient structure for organising knowledge.¹⁶⁹ Stereotypes are used to 'simplify and organise social information'.¹⁷⁰ The suggestion of this theory is that stereotyping, or labelling occurs because it is too difficult to take in all of the complexities of other people as individuals. Categorisation affords an efficient means to mentally organise large blocks of information enabling a simple, organised and predictable management of the human experience.¹⁷¹

Stereotyping is not always detrimental for example, as the economic advantages associated with stereotyping Australia as a place of sun, beaches and kangaroos. The real problem arises when rigid, negative stereotypes are acted upon in discriminatory ways.¹⁷² Stereotyping is about selective perceptions of who should be categorised on the basis of exaggerated differences between the stigmatiser and the stigmatised. The exaggeration of difference is conveyed via the perpetuation of stereotypical misconceptions intended to maintain the schism of social distance that exists between 'them' and 'us'. Therefore, the identification of difference, and sameness, is central to social selection. By exaggerating the differences in one group, the differences in the other group will be obscured.¹⁷³

¹⁶⁷ Merton and Bateman, above n 109.

¹⁶⁸ Nicolas Rüsch, Matthias C Angermeyer and Patrick W Corrigan, 'Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma' (2005) 20 *European Psychiatry* 529.

¹⁶⁹ Allison J Gray, 'Stigma in psychiatry' (2002) 95 *Journal of the Royal Society of Medicine* 72, 72.

¹⁷⁰ Ana I Balsa and Thomas G McGuire, 'Prejudice, Clinical Uncertainty and Stereotyping as Sources of Health Disparities' (2003) 22 *Journal of Health Economics* 89, 103.

¹⁷¹ Todd D Nelson (ed), *Handbook of prejudice, stereotyping, and discrimination* (Psychology Press, 2009).

¹⁷² Gray, above n 169, 72.

¹⁷³ Peter Byrne, 'Stigma of mental illness and ways of diminishing it' (2000) 6 *Advances in Psychiatric Treatment* 65, 66.

Attitudes based on the difference of people who are experiencing a mental illness, or their 'Otherness',¹⁷⁴ succeed in forging the image of someone who is incapable, dangerous and unpredictable and standing outside acceptable standards of normal behaviour. Classification as an 'Other' facilitates the person's stigmatisation as a member of a marginalised, subordinated and ostracised group. The powerfully normal develop an institution of rules that perpetuate the inferiority of the powerless group so as to ensure that the separation between the two groups is maintained.

Irrationality, indelibly associated with mental illness, lays the foundation for the deep seated stereotypical assumption that the person is unable to exercise their full citizenship responsibilities because they are unable to contribute, deliberate, negotiate, and compromise in the process of working with others to achieve the common good.¹⁷⁵ Irrationality is the justification for negating, or severely compromising the person's capacity to fully participate in society although mental illness and mental incapacity are not synonymous. As a consequence of irrationality, the 'mentally ill' group has been consigned to an inferiority position of 'half citizenship', a status that both justifies, and necessitates, their continued subjugation to the authority of the rational powerful.¹⁷⁶

5.1 Stereotypical misconceptions

There are three commonly held stereotypical misconceptions that provide the three elements that underpin the public's stigmatised attitudes toward the mentally ill: authoritarianism, benevolence and fear.¹⁷⁷ Authoritarianism is responsible for generating the greatest number of misconceptions such as the belief that only weak or feeble people who lack direction in life become mentally ill; they are lazy; only the elderly suffer from depression; the person themselves is responsible for becoming

¹⁷⁴ A number of contemporary identity theorists using a Self/Other dichotomy, distinguish the Other from the Self as a way of distinguishing one person from another.

¹⁷⁵ Allison C Carey, *On the Margins of Citizenship* (Temple University Press, 2009).

¹⁷⁶ Pauline Prior, 'Citizenship and Mental Health Policy in Europe' (2007) 5 *Social Work and Society* 115, 117. 'The overwhelming message from people with mental illnesses is that they are not functioning as full citizens'.

¹⁷⁷ Corrigan and Watson, above n 2. See also Patrick W Corrigan, Amy Kerr and Lissa Knudsen, 'The stigma of mental illness: Explanatory models and methods for change' (2005) 11 *Applied and Preventive Psychology*, 179. Also Paul E Holmes *et al.*, 'Changing attitudes about schizophrenia' (1999) 25 *Schizophrenia Bulletin* 447.

mentally ill;¹⁷⁸ and the application of sufficient willpower can cure psychopathological problems.¹⁷⁹

The second element is benevolence in which people with a mental illness are deemed helpless. They are naïve and inexperienced and possess a child-like perception of the world.¹⁸⁰ Their non-conforming free spirit is simply indicative of their irresponsibility which necessitates the state's intervention to ensure that acceptable and appropriate life decisions are made on their behalf. State intervention is commonly confined to two aspects of the free spirit's life: control of their finances¹⁸¹ and their forcible treatment¹⁸² although it can extend to other decision-making areas such as deciding where the person lives,¹⁸³ who they are allowed to associate with,¹⁸⁴ and whether they can work and where.¹⁸⁵ Having a childlike mentality enables the state's intervention in its authorisation of the statutory appointment of a benevolent guardian (often a state employee)¹⁸⁶ whose function is to ensure the proper provision of care and protection for the person.¹⁸⁷ In practice, guardians often usurp most, if not all of the significant decision-making rights previously exercised by the person. Viewed from a benevolent approach, people experiencing mental illness are non-conformists, living by their own life plan, unconstrained by society's conventions and lacking in worth as a contributor to the common good.

The final stereotypical misconception is fear. The qualities of dangerousness and unpredictability attributed to people experiencing a mental illness dictate apprehensiveness and avoidance in the stigmatiser. To minimise public risk,

¹⁷⁸ Attitudes to Mental Illness - 2011 survey report, published by The Health and Social Care Information Centre, NHS, United Kingdom, June 2011. In this survey, 16 per cent of respondents believe that one of the main causes of mental illness is lack of self-discipline and will-power. Mental Health America Attitudinal Survey in 2007 found that 22% of Americans believed that depression is a personal weakness. <http://www.mentalhealthamerica.net/go/go/news/10-year-retrospective-study-shows-progress-in-american-attitudes-about-depression-and-other-mental-health-issues>.

¹⁷⁹ Adrian Furnham and Susan Henley, 'Lay Beliefs about Overcoming Psychological Problems' (1988) 6 *Journal of Social and Clinical Psychology* 423. See also Chris R Brewin and Adrian Furnham, 'Attributional pre-attributional variables in self-esteem and depression: comparison and test of learned helplessness theory' (1986) 50 *Journal of Personality and Social Psychology* 1013.

¹⁸⁰ Nicolas Rüsch, Matthias C Angermeyer and Patrick W Corrigan, 'Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma' (2005) 20 *European Psychiatry* 529, 530.

¹⁸¹ *Guardianship and Administration Act* 1995 (Tas) s 51.

¹⁸² *Mental Health Act* 1996 (Tas) s 32(2).

¹⁸³ *Guardianship and Administration Act* 1995 (Tas) s 25(2)(a).

¹⁸⁴ *Ibid* s 25(2)(d).

¹⁸⁵ *Ibid* s 25(2)(c).

¹⁸⁶ *Ibid* s 14.

¹⁸⁷ *Ibid* s 15.

jurisdictions have enacted extraordinary civil commitment laws which give power to police to enter premises without warrant¹⁸⁸ so as to take health clients into custody and forcibly transport them to hospitals and health centres for involuntary psychiatric assessment and treatment;¹⁸⁹ admit the ill, non-criminal to secure forensic mental health units;¹⁹⁰ and deprive individuals of their liberty indefinitely, without trial.¹⁹¹ Benevolence legislation spreads its authoritative umbrella over the mentally impaired but because society does not fear or loathe the demented elderly, intellectually disabled, or people with an acquired brain injury, the state does not impose the same level of restrictive and controlling power over these groups that it does over the ‘mentally ill’ group.

All three misconceptions result in the authority of the state meted through its instrument, the law, to forcefully deprive individuals of their fundamental rights to liberty, bodily integrity and autonomous decision-making *via* involuntary and coerced treatment regimes, and civil commitment and guardianship legal processes. Authoritarianism supports the expectation that the individual should willingly engage in their treatment and they are sufficiently blamed to justify their legal compulsion. Benevolence and fear support the framework of laws that reduce the status of the adult person experiencing a mental illness to that of a vulnerable, erratic and threatening child requiring special management by the parent - the state – which both mirrors and reinforces the public stereotypical views that normal people need to distance themselves from the abnormality of mental illness.

5.2 Social Distance

Stigma represents a kind of death – a social death. Nonstigmatised people, through avoidance and social rejection, often treat stigmatised people as if they were invisible, nonexistent, or dead.¹⁹²

¹⁸⁸ *Mental Health Act* 1996 s 15(2).

¹⁸⁹ *Ibid* s 16(1)(a).

¹⁹⁰ *Ibid* s 72B(1).

¹⁹¹ Jurisdictions differ in the precise statutory processes regarding review procedures, length of time between reviews, etc. In Tasmania, the Mental Health Tribunal reviews involuntary hospitalizations 6 monthly (s 29 (1)); as an informal process (s.56(2)), without regard to technicalities or legal forms (s.56 (1)(a)); is not bound by Rules of Evidence (s.58(1)); does not guarantee representation for patients; is not compelled to produce hearing transcripts or Statement of Reasons; and the Act is silent on the right of appeal. One tribunal member can hear the proceedings (s.49 (2)) and there is no requirement that that person is a lawyer.

¹⁹² Lerita Coleman Brown, ‘Stigma: An enigma demystified’ in Lennard J Davis (ed), *The Disability Studies Reader* (Routledge, 1997) 216, 226.

The consequence of stereotypes, prejudice and discrimination is the imposition of interactional/social distance with the amount of distance imposed measured by the level of intimacy required.¹⁹³ The concept of social distance is conceptualised in a number of different ways including affective social distance which determines the levels of social distance through feelings such as sympathy, fear, loathing, anger and pity which one group expresses toward another group.¹⁹⁴ Normative social distance refers to the distinctions between 'them' and 'us' and is expressed through the norms of social acceptability. The primary question in this concept is who is different and therefore, outside the normal majority.¹⁹⁵

Researchers use the construct of social distance to assess expected discriminatory behaviour toward adults with mental illness based on the opinion that it can provide valuable insight into factors that influence mental illness stigma. In 2006, Angermeyer *et al.* undertook a literature review of 33 national and 29 local and regional population studies of public beliefs about, and attitudes toward, people experiencing mental illness.¹⁹⁶ Angermeyer found that while the public majority considered that they were in need of help, a substantial proportion perceived them with unease, uncertainty and fear. There is a tendency to increase social distance when 54-85% of respondents thought that people with schizophrenia were unpredictable while 18-71% thought them to be dangerous.¹⁹⁷ Pescosolido reported that 71.8% of their study's respondents indicated that they would socially distance themselves from people who were drug dependent; 55.7% reported wanting to avoid interactions with people who were alcohol dependent (Angermeyer reported 65-71%); 48.4% said they would shun a person diagnosed with schizophrenia; and 37.4% said they would be unwilling to associate with a person diagnosed with a major depression.¹⁹⁸

These results were in line with results of other studies that found that the most socially isolated individuals were identified as those experiencing schizophrenia,

¹⁹³ Jack K Martin, Bernice A Pescosolido and Steven A Tuch, 'Of Fear and Loathing: The Role of 'Disturbing Behavior,' Labels, and Causal Attributions in Shaping Public Attitudes toward People with Mental Illness' (2000) 4 *Journal of Health and Social Behavior* 208.

¹⁹⁴ Jo C Phelan, 'Geneticization of Deviant Behavior and Consequences for Stigma: The Case of Mental Illness' (2005) 46 *Journal of Health and Social Behavior* 307.

¹⁹⁵ Nedim Karakayali, 'Social Distance and Affective Orientations' (2009) 24 *Sociological Forum* 538.

¹⁹⁶ Matthias C Angermeyer and S Deitrich, 'Public beliefs about and attitudes towards people with mental illness: a review of population studies' (2006) 113 *Acta Psychiatrica Scandinavica* 163.

¹⁹⁷ *Ibid.*, 170.

¹⁹⁸ Martin, Pescosolido and Tuch, above 193.

alcoholism, or who were drug abusers, and that there was greater public tolerance for people who have a serious mental illness than people who have alcohol or drug dependencies. In light of the recent trend worldwide in mental health services infrastructures, policies and programs towards creating a more homogenous service approach to mental illness/alcohol/drug dependency via the concepts of co-morbidity, co-occurrence and dual diagnosis,¹⁹⁹ people experiencing a mental illness may become even more stigmatised, and rejected, in future.

5.2.1 Comorbidity

Recent national public health rationalisation processes have included support and implementation of comorbidity policies²⁰⁰ and service delivery²⁰¹ that has resulted in alcoholism and drug abuse/dependency becoming extrinsically linked to mental illness. Recent Australian research shows that the comorbid population is far from a homogenous group and that the co-occurrence of mental health issues and alcohol and other drugs (AOD) dependencies has failed to produce consistency in ideologies, frameworks, terminology, treatment approaches and professional knowledge. Consequently, a person may have their mental illness go undetected or untreated in the AOD setting; be labelled as difficult to treat; be denied services because of the complexity of their presentation; be ineligible for cross-referral; or be denied service altogether because they do not meet the treatment criteria because of their co-occurring disorders and complex needs.²⁰²

Co-morbidity has little advantage to the person experiencing a mental illness but it does afford them great disadvantage through further stigmatisation. When

¹⁹⁹ Queensland Health, 'Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems)' (Policy Paper, Queensland Government, 2008) <http://www.comorbidity.org.au/sites/default/files/Qld%20DD%20policy%20Oct%2008_0.pdf>. Maree Teesson and Lucy Burns (eds), 'National Comorbidity Project' (Research Paper, National Drug and Alcohol Research Centre, 2001) <<http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-publicat-document-metadata-comorbidity.htm>>.

²⁰⁰ Mental health policy implementation guide: dual diagnosis good practice guide; 2002. Department of Health (U.K.) <http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009058>. See also National comorbidity initiative: a review of data collections relating to people with coexisting substance use and mental health disorders. Cat. No. PHE 60. (Drug Statistics Series No. 14). Canberra: Australian Institute of Health and Welfare; 2005, <<http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442459660>>.

²⁰¹ Gavin Andrews, Scott Henderson and Wayne Hall, 'Prevalence, co-morbidity, disability and service utilisation, Overview of the Australian National Mental Health Survey' (2001) 178 *British Journal of Psychiatry* 145, 153.

²⁰² Rachel Canaway and Monika Merkes, 'Barriers to comorbidity service delivery: the complexities of dual diagnosis and the need to agree on terminology and conceptual frameworks' (2010) 34 *Australian Health Review* 262.

addressing a conference on mental health and homelessness in 2010, Michael Kirby, the then Chair of the Canadian Mental Health Commission, and former Australian High Court Justice stated that there is:

... a huge lack of compassion on the part of Canadians toward individuals who suffer from mental illness, who are homeless, or who suffer as a result of substance abuse ... If you have all three, the discrimination is colossal.²⁰³

Stigma is compounding and comorbidity attracts its own stigma because of the impact it has on the person's ability or capacity to deal effectively with their conditions²⁰⁴ and yet, despite the fact that the limited available evidence does not support co-morbid psychotherapeutic treatment,²⁰⁵ mental health agencies have adopted an integrated services approach. Clinical care and treatment services are delivered to people experiencing mental health problems such as substance abuse together with behavioural syndromes associated with permanent physiological disturbances and physical factors.²⁰⁶ Inappropriate behaviours arising from cerebral vascular accidents²⁰⁷ or a neurological disorder caused by alcoholism²⁰⁸ are being inextricably associated with mental illness and the label, 'mentally ill'.

5.2.2 *Hierarchy of acceptance*

The term hierarchy of acceptance refers to a structure of public preference toward marginalised groups with the level of acceptance of each group's distinct difference determining the group's ranking. In 1970, John Tringo modified the Bogardus scale²⁰⁹ to measure social distance between respondents and 21 disability groups. The study established that a hierarchy existed in which mental illness placed at the bottom of rankings indicating the greatest amount of social distance. Tringo's results were mirrored by later studies that also rank mental illness at the bottom, or

²⁰³ Monte Paulsen, 'Canada short changes mental health care: Kirby', *The Tyee* (online), 22 June 2010 <<http://thetyee.ca/Blogs/TheHook/Health/2010/06/22/Canada-short-changes-mental-health/>>.

²⁰⁴ Netzach Goren and Jane Mallick 'Prevention and early intervention of coexisting mental health and substance use issues, Drug Info Clearing House, Issues Paper 3, November 2007 <http://www.druginfo.adf.org.au/attachments/347_PRQ03Nov07_final.pdf>.

²⁰⁵ Laurie Barclay, 'Integrated Treatment of Substance Use Disorders and Comorbid Conditions - A Literature Review', *Medscape* (online), 27 April 2009 <<http://www.medscape.com/viewarticle/701725>>.

²⁰⁶ Australian Institute of Health and Welfare (AIHW) 2005. Mental health services in Australia 2003–04. AIHW cat no. HSE 40. Canberra: AIHW (Mental Health Series no. 8). (Up to 4% of all mental health services provided by government services and agencies; 3% of private hospital services; 16% by General Practitioners)

²⁰⁷ Stroke

²⁰⁸ Korsakoff's syndrome

²⁰⁹ The sociologist E. S. Bogardus developed the 'Bogardus social distance scale' in 1925. The scale was used to measure the social-psychological distance between different ethnic and racial groups.

close to bottom in varying order with alcoholism and drug addiction.²¹⁰ Motivated by the liberalisation of public opinion, and the legislative rights changes that had occurred in the three decades since Tringo's study, Thomas²¹¹ tested whether the hierarchy still existed, and if so, how stable it was in what had generally become, more informed and more tolerant communities. He found that the 'hierarchy of preference of disabilities proposed by Tringo over 30 years ago remains firmly entrenched'.²¹²

6. DISCRIMINATION

Discrimination is a multifaceted phenomenon that exists explicitly in norms, values and institutions. It is not necessarily the deliberate, prejudicial treatment of a person, or a group of people who, on the basis of having a negatively valued difference, are considered to have less social worth. Discriminated people are subject to exclusions and restrictions that deny them the same opportunities of the social majority to participate fully in economic, social and political life.²¹³

Individual discrimination is the behaviour of individual members belonging to one group that is intended to have a differential and/or harmful effect on the members of another group.²¹⁴

Structural discrimination, sometimes called institutional or systemic discrimination, is entrenched in the structure and institutional patterns of behaviour and actions of organisational culture. It relates primarily to the ways in which norms, behaviour and rules intentionally, or unintentionally affect, and obscure, discriminatory and/or harmful effects on a stigmatised group, either because of prejudice, or because of a failure to take into account the particular needs of different social identities.²¹⁵

However, the idea of structural discrimination is that it represents an attempt to

²¹⁰ Stefan J Harasymiw, 'A longitudinal study of disability group acceptance' (1976) 37 *Rehabilitation Literature* 98. See also Gary L Albrecht, Vivian G Walker and Judith A Levy, 'Social distance from the stigmatised' (1982) 16 *Social Science and Medicine* 1319. Also David R Austin, 'Attitudes toward old age: a hierarchical study' (1985) 25 *The Gerontologist* 431.

²¹¹ Adrian Thomas, 'Stability of Tringo's Hierarchy of Preference Toward Disability Groups: 30 Years Later' (2000) 86 *Psychological Report* 1155.

²¹² Ibid.

²¹³ Craig Morgan *et al.*, 'Social exclusion and mental health: Conceptual and methodological review' (2007) 191 *The British Journal of Psychiatry* 477.

²¹⁴ Fred L Pincus, 'Discrimination comes in many forms: Individual, institutional, and structural' (1996) 40 *The American Behavioral Scientist* 186.

²¹⁵ Patrick W Corrigan, Fred E. Markowitz and Amy C. Watson, 'Structural levels of mental illness stigma and discrimination' (2004) 30 *Schizophrenia Bulletin* 481, 481.

capture a social wrong distinct from a direct discrimination. Pincus observed that ‘[t]he key element in structural discrimination is not the intent but the effect of keeping minority groups in a subordinate position’.²¹⁶

6.1 Structural discrimination

Structural discrimination refers to the policies and behaviours of the powerful group in the implementation of policies which are neutral in intent but have a discriminatory and or/harmful effect on the stigmatised group, leaving them vulnerable to a number of untoward circumstances.²¹⁷ It affects people in ways that cannot be explained by the direct psychological effects of an individual’s prejudiced attitudes and behaviours²¹⁸ and occurs ‘when an entire network of rules and practices disadvantage less empowered groups while serving at the same time to advantage the dominant group’.²¹⁹

Structural discrimination is the accumulated institutional practices and policies that work to the social disadvantage and political isolation of marginalised groups even when the prejudice or discrimination is not apparent.²²⁰ Informal habitual practices – ‘this is just the way things are done here’ – are covertly built into systems, making it much more difficult to identify structural discrimination than to identify personal bias or individual discrimination.²²¹ Examining an institution’s rules and practices through the ‘lens’ of structural discrimination, existing prejudices can be identified and appropriately addressed. With regard to mental illness, structural discrimination is tightly woven into social policies and organisational structures, service delivery, legislation, legal administration and practices to such an extent that not only is the prejudice largely unnoticed, but when it is noticed it is generally considered acceptable.

²¹⁶ Fred L Pincus and Howard J Ehrlich (eds), *Race and Ethnic Conflict: contending views on prejudice, discrimination, and ethnoviolence* (Westview Press 1994). Fred L Pincus, *From Individual to Structural Discrimination*, 84.

²¹⁷ Link and Phelan, above n 164, 373.

²¹⁸ Corrigan, Markowitz and Watson, above n 215.

²¹⁹ This definition was taken from the Equal Employment Opportunity Policy to 2010: Future Directions of EEO in the New Zealand Public Service, Appendix 1, Definitions and Key Concepts <http://www.ssc.govt.nz/node/5282>.

²²⁰ The Aspen Institute, ‘Structural Racism and Community Building’ (Forum Paper, The Aspen Institute Roundtable on Community Change, June 2004) <http://www.kintera.com/atf/cf/%7BDEB6F227-659B-4EC8-8F848DF23CA704F5%7D/aspen_structural_racism2.pdf>.

²²¹ Human Rights Commission, ‘A fair go for all? Rite tahi tātou katoa? Addressing Structural Discrimination in Public Services’ (Discussion Paper, New Zealand Human Rights Commission, July 2012) <<http://nhri.ohchr.org/EN/Themes/IndigenousPeoples/DocumentsPage/Addressing%20Structural%20Discrimination%20%20HRC%20New%20Zealand%20Structural%20%282012%29.pdf>>.

6.1.1 *Intentional structural discrimination – insurance policies*

Intentional structural discrimination against people experiencing a mental illness lies in the policies, rules and procedures of private and public entities in positions of power that consciously and purposefully restrict a person's rights, and limits their opportunities.²²² One area that serves as an example of the endemic of discrimination is insurance, which alongside financial services companies, routinely discriminates against people with mental illness in Australia.²²³ In Tasmania, s.30 of the insurance and superannuation section of the *Anti-Discrimination Act 1998* provides insurers with an exemption that makes it lawful to discriminate against an individual based on the person having 'certain attributes'. This exemption is a replication of the Commonwealth's *Disability Discrimination Act 1992* (DDA) which 'does not render it unlawful for a person to discriminate against another person, on the ground of the other person's disability when asked to sell insurance coverage for life or accident, 'or any other policy of insurance', or asked to grant membership to a superannuation or provident fund or scheme.'²²⁴ For the discrimination to be lawful it must be based upon actuarial or statistical data on which it is reasonable for the discriminating party to rely;²²⁵ or is reasonable having regard to the matter of the data and other relevant factors;²²⁶ or 'in the case where no such actuarial or statistical data is available and cannot reasonably be obtained - the discrimination is reasonable having regard to any other relevant factors.'²²⁷

In the 2004 review of the Australian DDA, the claim was made that 'unjustified, stereotyped 'relevant factors' are used to deny insurance to people with psychiatric disabilities'.²²⁸ In the circumstances where an insurance policy is issued, insurance industry standards allow increased rates by a percentage or a flat dollar amount (known as 'premium loading'), shorter periods for the insurance contracts and/or

²²² Corrigan, Markowitz and Watson, above n 215, 481.

²²³ Mental Health, Discrimination & Insurance (A Survey of Consumer Experiences 2011, Mental Health Council of Australia) <<http://www.beyondblue.org.au/docs/default-source/default-document-library/bw0129-report-mental-health-discrimination-and-insurance.pdf?sfvrsn=2>>

²²⁴ *Disability Discrimination Act 1992* s 46(2)(a), (b), (c), (d), (e).

²²⁵ *Ibid* s 46(2)(f)(i).

²²⁶ *Ibid* s 46(2)(f)(ii).

²²⁷ *Ibid* s 46(2)(g).

²²⁸ Report of the *Review of the Disability Discrimination Act* (Cth) 1992, Productivity Commission, Australian Government, 14 July 2004, 336. <<http://www.pc.gov.au/projects/inquiry/disability-discrimination/report>>.

exclusions for one or more medical conditions or risky activities in situations.²²⁹

While these insurance discrimination exemptions have been consistently used to deny insurance coverage to, or heavily penalise people experiencing, or having at some point in their lives experienced mental illness, there has been a recent trend away from the acceptability of having disability discriminatory exemptions in anti-discrimination legislation. This is generated largely by state compliance with the *Convention on the Rights of Persons with Disabilities*.²³⁰

The United Kingdom enacted the *Equality Act* 2010 which set new standards of fair treatment for people with a disability. The Act made it illegal for insurers to discriminate by refusing to provide a service, or to provide a service on worse terms than for non-disabled people which included increased premiums, on the basis of a the person having disclosed a present or past mental illness.²³¹ Historically, most United States' health insurers have categorically excluded mental health benefits from mainstream health coverage.²³² In an attempt to try to end this discrimination, and to place mental health benefits on an equal footing with medical and surgical benefits, the *Mental Health Parity and Addiction Equity Act* was passed as part of the *Emergency Economic Stabilization Act* of 2008. Under this new law, insurance companies were no longer arbitrarily able to limit the number of hospital days or outpatient treatment sessions, or assign higher co-payments or deductibles for those in need of psychological services.²³³

In Australia, it had been the first National Inquiry into the Human Rights of People living with Mental Illness (The Burdekin Report) in the early 1990s that first revealed the systemic nature of the discrimination that Australians who experienced mental illness face when applying for, or making claims against, insurance policies.²³⁴ This situation has not changed according to the *Discrimination &*

²²⁹ 'Mental illness and life insurance: What you need to know – a detailed guide' (Information Sheet, Beyond Blue, Mental Health Council of Australia, Lifewise and the Financial Planning Association, 2010) <<http://www.psychology.org.au/assets/files/mental-illness-and-life-insurance-detailed-guide.pdf>>.

²³⁰ *United Nations Convention on the Rights of Persons with Disabilities*, GA Res 61/106 (17 July 2008).

²³¹ Part 3 - s.29

²³² Richard A Garcia, 'Equity for All? Potential Impact of the Mental Health Parity and Addiction Act of 2008' (2010) 31 *Journal of Legal Medicine* 137.

²³³ *Mental Health Parity and Addiction Equity Act* 2008 (U.S.)

²³⁴ HREOC (1993) Report of the National Inquiry into the Human Rights of People with Mental Illness, http://www.hreoc.gov.au/human_rights/mental_illness/national_inquiry.html.

*Insurance: A Survey of Consumer Experiences 2011*²³⁵ paper which reported that Australians with a history of mental illness continue to experience significant discrimination and difficulty obtaining insurance products that are otherwise readily available to people without a history of mental illness, and when trying to make a claim against their existing policies.

Consumers reported that insurance companies make broad and stigmatised assumptions about their ability to maintain their employment, and their general level of function to the extent that they are subjected to higher premiums, have exclusions placed on their policies, or are refused coverage outright. Interestingly, rather than calling for legislation similar to the UK's *Equality Act* and America's *Mental Health Parity and Addiction Equity Act* to be enacted in Australia, the report blandly concluded that:

... much needs to be done to break down misinformation and the lack of knowledge that exists within the insurance and financial sectors in relation to mental illness ... it will be interesting to see what changes are made and whether consumer and carer experiences improve over time. The results from this survey will be used to advocate attitudinal changes through improved knowledge and awareness about mental illness within the insurance and financial sectors.²³⁶

6.1.2 Unintentional structural discrimination - health parity

When unintentional structural discrimination occurs, it results in fewer opportunities for people experiencing a mental illness even when there is a principle, policy or legislative commitment to neutrality.²³⁷ In 1997, the *Mental Health Parity Act* 1996 was signed into law in the United States.²³⁸ The Act required that lifetime and annual health care limits were to be set at a similar level for mental health benefits as for medical and surgical benefits. At the time, typical health care coverage included \$50,000 lifetime/\$5,000 annual caps on mental illness

²³⁵ Mental Health Council of Australia, 'Mental Health, Discrimination & Insurance: A Survey of Consumer Experiences 2011' (Report, Mental Health Council of Australia and Beyondblue, 2011) <http://www.beyondblue.org.au/index.aspx?link_id=4.62&tmp=File Download&fid=2444>.

²³⁶ Carmen DeNavas-Walt, Bernadette D Proctor and Jessica C Smith, 'Income, Poverty, and Health Insurance Coverage in the United States: 2010' (Report No P60-239, United States Census Bureau, September 2011) 56 <<http://www.census.gov/prod/2011pubs/p60-239.pdf>>.

²³⁷ Corrigan, Markowitz and Watson, above n 215, 481.

²³⁸ *Mental Health Parity Act*, S. 2031, 104th Cong. (1996).

benefits in contrast to the \$1 million lifetime/no annual caps for somatic illnesses.²³⁹ Even after it was enacted into law, insurers were still able to impose significant restrictions on mental health benefits.²⁴⁰

The Act did not make it compulsory for employers to provide mental health coverage, although according to the United States Census Bureau 55% of Americans obtained their insurance through an employer.²⁴¹ The Act exempted altogether companies with 50 or fewer employees. The Act did not ‘require health plans to provide mental health services, but merely regulated those health care plans that already offered mental health coverage’²⁴² and moreover, most employers that had health plans with mental health coverage were already compliant with the provisions of the Act.²⁴³ Although the idea of equal health care for mental illness had wide political and public support, the business and financial issues and particularly, the public concern regarding the necessity for higher premiums for all, and concern regarding the redistribution of funds from medical/surgical services necessary to achieve the desired goal meant that there was a lack of practical support for the provisions of the Act.²⁴⁴

The 2008 *Mental Health Parity and Addiction Equity Act* was intended to close many of the loopholes in the 1996 Act although it continues to maintain employer exemptions that had been at the financial root of problems in the 1996 Act.²⁴⁵ To date, the promise of the 2008 Act has not been realised as a final rule has not been issued on key provisions necessary to make the Act fully operational. Critics suggest that in practice, the Act ‘will do little to ensure equality of mental health benefits under the current health care landscape.’²⁴⁶ Insurance companies continue to impose stringent limits on addiction/mental health benefits that prevent patients from fully accessing the benefits they were promised under their health plan, and

²³⁹ National Alliance on Mental Illness, The Mental Health Parity Act of 1996, <http://www.nami.org/Content/ContentGroups/E-News/1996/The_Mental_Health_Parity_Act_of_1996.htm>

²⁴⁰ Garcia, above n 232.

²⁴¹ DeNavas-Walt, Proctor and Smith, above n 236.

²⁴² Garcia, above n 230, 141.

²⁴³ Kevin D Hennessy and Howard H Goldman, ‘Full Parity: Steps Toward Treatment Equity for Mental and Addictive Disorders’ (2001) 20 *Health Affairs* 58.

²⁴⁴ Corrigan, Markowitz and Watson, above n 215, 481.

²⁴⁵ Ibid.

²⁴⁶ Garcia, above n 232, 154.

insurers refuse to disclose the criteria used to make denials on comparable medical benefits.²⁴⁷

The U.S. Government Accountability Office's report issued on May 31, 2012 showed that the percentage rise of treatment exclusions in health plans from 2008 to 2011 included behavioural disorders 30.8% from 11.1%, attention deficit disorder 5.1% from 0.0% and residential treatment facility 15.4% from 11.1%.²⁴⁸ 'As a result of the lack of guidance regarding final regulations from the administration, many individuals seeking care for mental health and addiction disorders are unable to access the services they need'.²⁴⁹ When funding is insufficient, and there are fewer resources available for mental illness in contrast to medical illness, the opportunities for people experiencing mental illness are diminished.²⁵⁰

6.2 Structural discrimination in Australia

The mental health sector in Australia is seriously underfunded and under-resourced and yet mental illness is the country's leading cause of disability, accounting for 13% of the total burden of disease while only 6% of the entire health budget is spent on mental health care.²⁵¹ Mental health research receives a lower proportion of health funding than other National Health Priority Areas²⁵² such as cancer, diabetes and cardiovascular disease, with a significant proportion of the mental health research funding directed toward ageing.²⁵³ Studies show that the public

²⁴⁷ Letter written jointly by Republican Congressmen John Sullivan and Democrat Congressman Tim Ryan, 'Mental Health Parity: Where's the final rule?' October 5, 2012 requesting fellow Congressman to 'Please join the Addiction, Treatment, & Recovery Caucus in signing onto the letter below urging the U.S. Department of Labor, Health and Human Services, and Treasury to issue the final rule so that MHPAEA may be fully implemented.'

<<http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/APA%20on%20the%20Issues/09-25-2012-MHPAEA-2012-Letter---DC---FINAL.pdf>>

²⁴⁸ Letter from John E Dicken, Director Health Care to George Miller, Ranking Member Committee on Education and the Workforce, 31 May 2012 (*United States Government Accountability Office*, Washington) <<http://www.gao.gov/assets/600/591261.pdf>>.

²⁴⁹ Sullivan and Ryan letter, above n 247.

²⁵⁰ Carolyn Levinson and Benjamin G Druss, 'The evolution of mental health parity in American politics' (2000) 28 *Administration and Policy in Mental Health* 139.

²⁵¹ Louise Newman, Submission to the Standing Committee on Finance and Public Administration, *Inquiry into the Council of Australian Governments reforms relating to health and hospitals*, 26 May 2010 <<http://www.ranzcp.org/Files/ranzcp-attachments/Resources/Submissions/sub39-pdf.aspx>>.

²⁵² The NHPA initiative, established in 1996, is a program emphasising collaborative action between Australia's Commonwealth and State and Territory governments, non-government organisations, health experts, clinicians and consumers, for specific diseases and conditions including mental health.

²⁵³ Helen Christensen *et al.*, 'Funding for mental health research: the gap remains' (2011) 195 *The Medical Journal of Australia* 681.

clearly favours prioritising the limited health funding toward somatic illness over mental illness, placing mental health care funding at a distinct disadvantage.²⁵⁴

That the sector is insufficiently resourced has historically ‘bedevilled community based-care’.²⁵⁵ This has been particularly so in regional and remote areas because 81% of Australian psychiatrists practice in the capital cities.²⁵⁶ WHO reported that in the South East Asia region between 2001 and 2004, there had been a 40% decrease in the number of practising psychiatrists and a 60% decrease in the number of psychiatric nurses.²⁵⁷ Doctors and nurses are no longer choosing psychiatric specialisation in what is now a global problem of underfunded and under resourced mental health systems, turning instead to the financial rewards, prestige and minimised risks of working in other areas of health care.

Psychiatric hospitals, treatment centres and supported accommodation facilities are commonly established in isolated areas or in disadvantaged urban settings where the already stigmatised community members themselves lack the social power to exclude another marginalised and stigmatised group. Care and treatment is generally provided by less accomplished professionals in under resourced public hospital settings because the more successful and accomplished mental health professionals gain more status and financial benefits from treating patients with less serious mental illnesses in private practices situated in affluent areas.²⁵⁸ Psychiatric patients are excluded from life sustaining and improved quality of life medical procedure waiting lists on the basis of their diagnosis even though there has been little research done to establish that there is a link between psychosocial variables and poor medical outcomes.²⁵⁹ Also, the ability to access mental health resources

²⁵⁴ Georg Schomerus, Herbert Matschinger and Matthias C Angermeyer, ‘Preferences of the public regarding cutbacks in expenditure for patient care: Are there indications of discrimination against those with mental disorders?’ (2006) 41 *Social psychiatry and psychiatric epidemiology* 369.

²⁵⁵ ‘Human Rights and Mental Illness. Report of the National Inquiry into the Human Rights of People with Mental Illness’ (Report, Human Rights and Equal Opportunity Commission, 1993) 137.

²⁵⁶ The Royal Australian and New Zealand College of Psychiatrists, ‘Environmental Scan Component of the Mental Health Professionals’ Association Multidisciplinary Training Resource Program’ (Final Report, The Royal Australian and New Zealand College of Psychiatrists, January 2008).

²⁵⁷ World Health Organization, ‘Mental Health Atlas 2005: Evidence and Research Department of Mental Health and Substance Abuse World Health Organisation’ (Report, World Health Organization, 2005) 45.

²⁵⁸ Bruce G Link and Jo C Phelan, ‘On Stigma and Its Public Health Implications’ (Paper presented at On Stigma and Its Public Health Implications, Bethesda Maryland USA, 5 – 7 September 2001) <<http://www.stigmaconference.nih.gov/FinalLinkPaper.html>>.

²⁵⁹ Leon Phipps, ‘Psychiatric evaluation and outcomes in candidates for heart transplantation’ (1997) 20 *Clinical and Investigative Medicine* 388.

can be severely diminished by the inadequacies of social systems such as transport, health and social services.²⁶⁰

For some commentators, the very existence of distinct mental health legislation is in itself evidence of structural discrimination because it unfavourably distinguishes one particular group, one particular condition, and one particular disability.²⁶¹

Mental health acts make it lawful to deprive a person of their liberty and their right to bodily integrity based on the suspicion of a mental illness.²⁶² People living in the community can be compelled to undergo treatment as a preventative measure, so as to minimise the likelihood of them becoming unwell in the future, even though they may not be unwell at the time that they are under compulsion.²⁶³ These types of unique structural discriminations both contribute to, and reinforce the stereotypical view of people who experience mental illness as being different, helpless and dangerous, and someone who is in need of social control by the legal system.

7. CONCLUSION

A significant component of stigmatisation is the implicit association of mental illness with the moral concepts of 'helpless', 'bad' and 'blameworthy' which has helped to strongly link mental illness to misconceptions of dangerousness, vulnerable incapability and irresponsibility. Myths and fears provide fertile ground for stigma to flourish and the public's feelings of pity, fear and loathing flow from, and contribute to its deep seated prejudicial attitudes regarding mental illness. The 'mentally ill' are categorised as different, dysfunctional and inferior which in turn justifies the legal system's necessary intervention in the control and management of their behaviour, and the restrictions placed on their rights and interests. Stigma provides the foundation for the legal system's discrimination against people who experience mental illness.

²⁶⁰ Graham Currie, Janet Stanley and John Stanley (eds), *No Way To Go: Transport And Social Disadvantage In Australian Communities* (Monash University ePress, 2007).

²⁶¹ George Szmukler and Frank Holloway, 'Mental health legislation is now a harmful anachronism' (1998) 22 *Psychiatric Bulletin* 662.

²⁶² *Mental Health Act 1996* (Tas) requires the appearance of a mental illness for involuntary hospitalization to occur.

²⁶³ *Mental Health Act 1996* (Tas) s 44 authorizes the making of, and indefinite renewal of a community treatment orders lasting 12 months at a time if the person is of significant risk of harm if not treated, with 'harm' defined as a deterioration of their illness. Clinicians argue that if the treatment is stopped their mental health will deteriorate which is the justification for forcibly treating them when they are well, possibly for the rest of their life.

Goffman's conceptualisation of stigma as disqualification from full social acceptance has guided a wide range of social research studies, many of which this thesis has relied on in its argument that stigma propagates in power situations when there is a co-occurrence of labelling, negative stereotyping, exclusion, discrimination, and low status.²⁶⁴ Although these terms are commonly used interchangeably with stigma, 'stigma is a broader and more inclusive concept than any one of these processes'.²⁶⁵ There is a social responsibility to appreciate stigma if the legal and health systems are to cease being influenced by stereotypes, prejudices, and unfounded speculation that magnify risk, or by misguided expectations about the benefits of restrictive policies. It is important that public understanding and social policies regarding stigma are informed by the research, including the influential studies presented in this chapter.

Stigma is a destructive social phenomenon and people who live with mental illness are amongst the most stigmatised groups in society.²⁶⁶ According to Perlin, its destructiveness pervades the legal system. Instead of providing the person with a mental illness with a neutral and even 'playing field', the legal system stereotypically and unfairly stigmatises and discriminates against them as was shown in the example of insurance coverage. So far, the stigma associated with mental illness has largely been resistant to the policy, legal and cultural efforts to reduce its negative impact which is the topic explored in the following, Chapter Four.

²⁶⁴ Phelan and Link, above n 138.

²⁶⁵ Major and O'Brien, above n 120, 395.

²⁶⁶ Stuart, above n 5.

BIBLIOGRAPHY

A. Articles

Albrecht, Gary L, Vivian G Walker, and Judith A Levy, 'Social distance from the stigmatised' (1982) 16 *Social Science and Medicine* 1319.

Andrews, Gavin, Scott Henderson, and Wayne Hall, 'Prevalence, co-morbidity, disability and service utilisation, Overview of the Australian National Mental Health Survey' (2001) 178 *British Journal of Psychiatry* 145.

Angermeyer, Matthias C, and S Deitrich, 'Public beliefs about and attitudes towards people with mental illness: a review of population studies' (2006) 113 *Acta Psychiatrica Scandinavica* 163.

Angermeyer, Matthias C, and Herbert Matschinger, 'The effect of personal experience with mental illness on the attitude toward individuals suffering from mental disorders' (1996) 31 *Social Psychiatry and Psychiatric Epidemiology* 321.

Austin, David R, 'Attitudes toward old age: a hierarchical study' (1985) 25 *The Gerontologist* 431.

Bachrach, Leona L, 'Deinstitutionalization of mental health services in rural areas' (1977) 28 *Hospital and Community Psychiatry* 669.

Balsa, Ana I, and Thomas G McGuire, 'Prejudice, Clinical Uncertainty and Stereotyping as Sources of Health Disparities' (2003) 22 *Journal of Health Economics* 89.

Bassuk, Ellen L, and Samuel Gerson, 'Deinstitutionalization and mental health services' (1978) 238 *Scientific American* 46.

Borinstein, Andrew B, 'Public attitudes toward persons with mental illness' (1992) 11 *Health Affairs* 186.

Boyd, Robert, 'Presidential address: The Care and Treatment of the Insane Poor' (1870) 17 *Journal of Mental Science* 315.

Braslow, Joel T, 'History and Evidence-Based Medicine: Lessons from the History of Somatic Treatments from the 1900s to the 1950s' (1999) 1 *Mental Health Services Research* 231.

Brewin, Chris R, and Adrian Furnham, 'Attributional pre-attributional variables in self-esteem and depression: comparison and test of learned helplessness theory' (1986) 50 *Journal of Personality and Social Psychology* 1013.

Burris, Scott, 'Stigma and the law' (2006) 367 *The Lancet* 529.

Burrows, Graham, and John W Tiller, 'Cade's observation of the antimanic effect of lithium and early Australian research' (1999) 33 *Australian and New Zealand Journal of Psychiatry* 27.

Byrne, Peter, 'Stigma of mental illness and ways of diminishing it' (2000) 6 *Advances in Psychiatric Treatment* 65.

Canaway, Rachel, and Monika Merkes, 'Barriers to comorbidity service delivery: the complexities of dual diagnosis and the need to agree on terminology and conceptual frameworks' (2010) 34 *Australian Health Review* 262.

Christensen, Helen, *et al.*, 'Funding for mental health research: the gap remains' (2011) 195 *The Medical Journal of Australia* 681.

Corrigan, Patrick W, 'Mental health stigma as social attribution: Implications for research methods and attitude change' (2000) 7 *Clinical Psychology Science and Practice* 48.

Corrigan, Patrick W, Amy Kerr and, Lissa Knudsen, 'The stigma of mental illness: Explanatory models and methods for change' (2005) 11 *Applied and Preventive Psychology*, 179

Corrigan, Patrick W, and Amy C Watson, 'The paradox of self-stigma and mental illness' (2002) 9 *Clinical Psychology, Science and Practice* 35.

Corrigan, Patrick W, and Amy C Watson, 'Understanding the impact of stigma on people with mental illness' (2002) 1 *World Psychiatry* 16.

Corrigan, Patrick W, Fred E. Markowitz and Amy C. Watson, 'Structural levels of mental illness stigma and discrimination' (2004) 30 *Schizophrenia Bulletin* 481.

Crossley, Nick, 'R. D. Laing and the British anti-psychiatry movement' (1999) 47 *Social Science & Medicine* 877.

Draine Jeffrey, *et al.*, 'Role of Social Disadvantage in Crime, Joblessness, and Homelessness Among Persons With Serious Mental Illness' (2002) 53 *Psychiatry Services* 565.

Duffy, Lynne, 'Suffering, shame, and silence: The stigma of HIV/AIDS' (2005) 16 *Journal of the Association of Nurses in AIDS care* 13.

Elliott, Gregory C, 'Understanding stigma: dimensions of deviance and coping' (1982) 3 *Deviant Behavior* 275.

Foerschner, Allison, 'The History of Mental Illness: From "Skull Drills" to "Happy Pills"' (2010) 2 *Student Pulse* 1.

Furnham, Adrian, and Susan Henley, 'Lay Beliefs about Overcoming Psychological Problems' (1988) 6 *Journal of Social and Clinical Psychology* 423.

Garcia, Richard A, 'Equity for All? Potential Impact of the Mental Health Parity and Addiction Act of 2008' (2010) 31 *Journal of Legal Medicine* 137.

Goffman, Erving, 'The moral career of the mental patient' (1959) 22 *Psychiatry: Journal for the Study of Interpersonal Processes* 123.

Gray, Allison J, 'Stigma in psychiatry' (2002) 95 *Journal of the Royal Society of Medicine* 72.

Grob, Gerald N, 'Mental Health Policy in America: Myths and Realities' (1992) 11 *Health Affairs* 7.

Grob, Gerald N, 'The Paradox of Deinstitutionalization' (1995) 32 *Society* 51.

- Gustafson, W Mark, 'Inscripta in Fronte: Penal Tattooing in Late Antiquity' (1997) 16 *Classical Antiquity* 79.
- Harasymiw, Stefan J, 'A longitudinal study of disability group acceptance' (1976) 37 *Rehabilitation Literature* 98.
- Harris, Kristine, 'Pride and Prejudice – Identity and stigma in leprosy work' (2011) 82 *Leprosy Review* 135.
- Hennessey, Kevin D, and Howard H Goldman, 'Full Parity: Steps Toward Treatment Equity for Mental and Addictive Disorders' (2001) 20 *Health Affairs* 58.
- Hinshaw, Stephen P, and Andrea Stier, 'Stigma as Related to Mental Disorders' (2008) 4 *Annual Review of Clinical Psychology* 367.
- Holmes, Paul E, *et al.*, 'Changing attitudes about schizophrenia' (1999) 25 *Schizophrenia Bulletin* 447.
- Jensen, Louise, and Marion Allen, 'Wellness: The Dialectic of Illness' (1993) 25 *Journal of Nursing Scholarship* 220.
- Jones, Christopher P, 'Stigma: Tattooing and Branding in Graeco-Roman Antiquity' (1987) 77 *The Journal of Roman Studies* 139.
- Karakayali, Nedim, 'Social Distance and Affective Orientations' (2009) 24 *Sociological Forum* 538.
- Kristine Harris, 'Pride and Prejudice – Identity and stigma in leprosy work' (2011) 82 *Leprosy Review* 135.
- Lamb, Richard, 'Deinstitutionalization and the homeless mentally ill' (1984) 35 *Hospital & Community Psychiatry* 899.
- Lebel, Sophie, and Gerald M Devins, 'Stigma in cancer patients whose behavior may have contributed to their disease' (2008) 4 *Future Oncology* 717.
- Levinson, Carolyn, and Benjamin G Druss, 'The evolution of mental health parity in American politics' (2000) 28 *Administration and Policy in Mental Health* 139.
- Lopez-Ibor, Juan J, 'The power of stigma' (2002) 1 *World Psychiatry* 23.
- López-Muñoz, Francisco, *et al.*, (2005) 'History of the discovery and clinical introduction of chlorpromazine' (2005) 17 *Annals of Clinical Psychiatry* 113.
- Louis C Charland, 'Benevolent theory: moral treatment at the York Retreat' (2007) 18 *History of Psychiatry* 61.
- MacLean, Lynne, *et al.*, 'Obesity, stigma and public health planning' (2009) 24 *Health Promotion International* 88.
- Macq, Jean, *et al.*, 'Assessing the stigma of tuberculosis' (2006) 11 *Psychology, Health and Medicine* 346.
- Major, Brenda, and Laurie T O'Brien, 'The Social Psychology of Stigma' (2005) 56 *Annual Review of Psychology* 393.

Martin, Jack K, Bernice A Pescosolido, and Steven A Tuch, 'Of Fear and Loathing: The Role of 'Disturbing Behavior,' Labels, and Causal Attributions in Shaping Public Attitudes toward People with Mental Illness' (2000) 4 *Journal of Health and Social Behavior* 208.

Mechanic, David, and David A Rochefort, 'Deinstitutionalization: An Appraisal of Reform' (1990) 16 *Annual Review of Sociology* 301.

Mills, Mark J, and Bonnie D Cummins, 'Deinstitutionalization Reconsidered' (1982) 5 *International Journal of Law and Psychiatry* 271.

Morgan, Craig, *et al.*, 'Social exclusion and mental health: Conceptual and methodological review' (2007) 191 *The British Journal of Psychiatry* 477.

Murphy, Elaine, 'A mad house transformed: the lives and work of Charles James Beverly FRS (1788 - 1868) and John Warburton MD FRS (1795-1847)' (2004) 58 *Notes and Records of the Royal Society of London* 267.

Murphy, Elaine, 'The Mad-house Keepers of East London' (2001) 51 *History Today* 29.

Myers, Eunice Doman, 'Workhouse or asylum: the nineteenth century battle for the care of the pauper insane' (1998) 22 *Psychiatric Bulletin* 575.

Opala, J, Boillot, F, (1996) Leprosy among the Iimba: Illness and healing in the context of world view, 42 *Social Science and Medicine* 3.

Paterson, Barbara L, 'The Shifting Perspectives Model of Chronic Illness' (2001) 33 *Journal of Nursing Scholarship* 21.

Penn, David L, and James Martin, 'The Stigma of Severe Mental Illness: Some Potential solutions for a Recalcitrant Problem' (1998) 69 *Psychiatric Quarterly* 235.

Phelan, Jo C, 'Geneticization of Deviant Behavior and Consequences for Stigma: The Case of Mental Illness' (2005) 46 *Journal of Health and Social Behavior* 307.

Phelan, Jo C, and Bruce Link, 'Conceptualizing Stigma' (2001) 27 *Annual Review of Sociology* 363.

Phelan, Jo C, *et al.*, 'Public conceptions of mental illness in 1950 and 1996: what is mental illness and is it to be feared' (2000) 41 *Journal of Health and Social Behavior* 188.

Phipps, Leon, 'Psychiatric evaluation and outcomes in candidates for heart transplantation' (1997) 20 *Clinical and Investigative Medicine* 388.

Pincus, Fred L, 'Discrimination comes in many forms: Individual, institutional, and structural' (1996) 40 *The American Behavioral Scientist* 186.

Porpora, Douglas V, 'Four Concepts of Social Structure' (1989) 19 *Journal for the Theory of Social Behaviour* 195.

Prior, Pauline, 'Citizenship and Mental Health Policy in Europe' (2007) 5 *Social Work and Society* 115.

Richardson, Thomas H, 'Conceptual and Methodological Challenges in Examining the Relationship between Mental Illness and Violent Behaviour and Crime' (2009) *Internet Journal of Criminology* 1.

Ritsher, Jennifer Boyd, Poorni G Otolingam, and Monica Grajales, 'Internalized stigma of mental illness: psychometric properties of a new measure' (2003) 121 *Psychiatry Research* 1.

Rollin, Henry R, 'Psychiatry at 2000, A bird's eye view' (2000) 24 *Psychiatric Bulletin* 11.

Rüsch, Nicolas, Matthias C Angermeyer, and Patrick W Corrigan, 'Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma' (2005) 20 *European Psychiatry* 529.

Schomerus, Georg, Herbert Matschinger, and Matthias C Angermeyer, 'Preferences of the public regarding cutbacks in expenditure for patient care: Are there indications of discrimination against those with mental disorders?' (2006) 41 *Social psychiatry and psychiatric epidemiology* 369.

Schulze, Beate, and Matthias C Angermeyer, 'Subjective experiences of stigma: A focus group study of schizophrenic patients, their relatives and mental health professionals' (2003) 56 *Social Science & Medicine* 299.

Sheldon, Kathleen, and Linda Caldwell, 'Urinary incontinence in women: Implications for therapeutic recreation' (1994) 28 *Therapeutic Recreation Journal* 203.

Sommer, Robert, and Humphry Osmond, 'The Mentally Ill in the Eighties' (1981) 10 *Journal of Orthomolecular Psychiatry* 193.

Stanghellini, Giovanni, and Massimo Ballerini, 'Values in Persons with Schizophrenia' (2007) 33 *Schizophrenia Bulletin* 131.

Stier, Andrea, and Stephen P Hinshaw, 'Explicit and Implicit Stigma Against Individuals With Mental Illness' (2007) 42 *Australian Psychologist* 106.

Stuart, Heather, 'Fighting Stigma caused by mental disorders: past perspective, present activities, and future directions' (2008) 7 *World Psychiatry* 185.

Stuart, Heather, 'Violence and mental illness: an overview' (2003) 2 *World Psychiatry* 121.

Szmukler, George, and Frank Holloway, 'Mental health legislation is now a harmful anachronism' (1998) 22 *Psychiatric Bulletin* 662.

Talbott, John A, 'Deinstitutionalization: Avoiding the Disasters of the Past (A reprint from *Hospital and Community Psychiatry*)' (2004) 55 *Psychiatric Services* 1112.

Tennant, Margaret, 'Disability in New Zealand: An historical survey' (1996) 2 *New Zealand Journal of Disability Studies* 3.

Thomas, Adrian 'Stability of Tringo's Hierarchy of Preference Toward Disability Groups: 30 Years Later' (2000) 86 *Psychological Report* 1155.

Thornicroft, Graham, 'Stigma and discrimination limit access to mental health care' (2008) 17 *Epidemiologia e Psichiatria Sociale* 14.

Thornicroft, Graham, *et al.*, 'Stigma: ignorance, prejudice or discrimination?' (2007) 190 *British Journal of Psychiatry* 192.

Tomes, Nancy, 'The patient as a policy factor: a historical case study of the consumer/survivor movement in mental health' (2006) 25 *Health Affairs* 720.

Torrey, E Fuller, 'Stigma and Violence: Isn't It Time to Connect the Dots?' (2011) 37 *Schizophrenia Bulletin* 892.

Torrey, Fuller E, 'The Association of Stigma with Violence' (2011) 168 *The American Journal of Psychiatry* 235.

Unsworth, Clive, 'Law and Lunacy in Psychiatry's 'Golden Age'' (1993) 13 *Oxford Journal of Legal Studies* 479.

Underwood, Barbara D, 'Law and the Crystal Ball: Predicting Behavior with Statistical Inference and Individualized Judgment' (1979) 88 *Yale Law Journal* 1408.

van Luoma, Juliana, *et al.*, 'An investigation of stigma in individuals receiving treatment for substance abuse' (2007) 32 *Addictive Behaviour* 1331.

Ventrell, Marvin, 'Evolution of the Dependency Component of the Juvenile Court, 1899-1999' (1998) 49 *Juvenile and Family Court Journal* 1.

Wahl, Otto F, 'Mental Health Consumers' Experience of Stigma' (1999) 25 *Schizophrenia Bulletin* 467.

Weisberg, Robert, 'Restorative Justice and the Danger of "Community"' (2003) 42 *Utah Law Review* 343.

Weiss, Mitchell, Jayashree Ramakrishna, and Daryl Somma, 'Health-related stigma: Rethinking concepts and interventions' (2006) 11 *Psychology, Health & Medicine* 277.

Werner, Bernard, Raymond P Perry and Jamie Magnusson, 'An attributional analysis of reactions to stigmas' (1988) 55 *Journal of personality and social psychology* 738.

Whitaker, Robert, 'Anatomy of an Epidemic: Psychiatric Drugs and the Astonishing Rise of Mental Illness in America' (2005) 7 *Ethical Human Psychology and Psychiatry* 23.

Williams, S W D, 'Our Over-crowded Lunatic Asylums' (1872) 17 *British Journal of Psychiatry* 515.

B. Books

Bartlett, Steven James, *Normality Does Not Equal Mental Health: The Need to Look Elsewhere for Standards of Good Psychological Health* (Praeger, 2011).

Bloch, Sidney, *Understanding Troubled Minds: A Guide to Mental Illness and Its Treatment* (Melbourne University Publishing, 2nd ed, 2011).

Carey, Allison C, *On the Margins of Citizenship* (Temple University Press, 2009).

Corrigan, Patrick W, *On the Stigma of Mental Illness* (American Psychological Association, 2005).

Crocetti, Guido M, Herzl R Spiro and Iradj Siassi, *Contemporary Attitudes towards Mental Illness* (University of Pittsburgh Press, 1974).

Cummins, Cyril J, *A History of Medical Administration in New South Wales 1788-1973* (NSW Health, 2nd ed, 2003)

- Currie, Graham, Janet Stanley, and John Stanley (eds), *No Way To Go: Transport And Social Disadvantage In Australian Communities* (Monash University ePress, 2007).
- Davis, Lennard J (ed), *The Disability Studies Reader* (Routledge, 1997)
- Durkheim, Émile, *Rules of Sociological Method* (The Free Press, 1966)
- Forsythe, Bill and Joseph Melling (eds), *Insanity, Institutions and Society, 1800-1914* (Routledge, 2006).
- Foucault, Michel, *History of Madness* (Jean Khalfa (ed)) (Jonathan Murphy and Jean Khalfa trans) (Routledge, 2006).
- Goffman, Erving, (ed), *Asylums: essays on the social situation of mental patients and other in-mates* (Anchor Books, 1961).
- Goffman, Erving, *Stigma: notes on the management of spoiled identity* (Prentice-Hall, 1963).
- Hetherington, Penelope, *Paupers, poor relief and poor houses in Western Australia, 1829 to 1910* (University of Western Australia Publishing, 2009).
- Jones, Edward E, *et al.*, *Social Stigma: the Psychology of Marked to Relationships* (W.H. Freeman & Co., 1984).
- Nelson, Todd D, (ed), *Handbook of prejudice, stereotyping, and discrimination* (Psychology Press, 2009).
- Parry, John W, *Criminal Mental Health and Disability Law, Evidence and Testimony: A Comprehensive Reference Manual for Lawyers, Judges and Criminal Justice Professionals* (American Bar Association, 2009)
- Perlin, Michael L, *The Hidden Prejudice: Mental Disability on Trial* (American Psychological Association, 2000).
- Pincus, Fred L, and Howard J Ehrlich (eds), *Race and Ethnic Conflict: contending views on prejudice, discrimination, and ethnoviolence* (Westview Press 1994)
- Pols, Jan, *The Politics of Mental Illness: Myth and Power in the Work of Thomas S. Szasz* (Ebook) 122 <<http://janpols.net/>>.
- Porter, Roy, *Madness: A Brief History* (Oxford University Press, 2002).
- Rawls, John, *A Theory of Justice* (Harvard University Press, 1971).
- Rothstein, William G, *Readings in American health care: current issues in socio-historical perspective* (University of Wisconsin Press, 1995)
- Scully, Andrew, *The Most Solitary of Afflictions* (Yale University Press, 1993).
- Shorter, Edward, *History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (Wiley, 1997)
- Spitzer, Stephan P, and Norman K Denzin (eds), *The mental patient* (McGraw-Hill 1968)
- Szasz, Thomas S, (ed), *The Age of Madness* (Routledge & Keegan Paul, 1975).

Varcarolis, Elizabeth M, *Foundations of Psychiatric Mental Health Nursing* (W.B. Saunders Company, 2005).

Warner, Richard, *Recovery from Schizophrenia: Psychiatry and Political Economy* (Brunner-Routledge, 1985).

C. Grey Literature -Research Papers, Reports, Submissions, Letters, Memos etc

‘Attitudes to Mental Illness’ - 2011 survey report, published by The Health and Social Care Information Centre, NHS, United Kingdom, June 2011.

‘Environmental Scan Component of the Mental Health Professionals’ Association Multidisciplinary Training Resource Program’ (Final Report, The Royal Australian and New Zealand College of Psychiatrists, January 2008).

‘Human Rights and Mental Illness’. Report of the National Inquiry into the Human Rights of People with Mental Illness’ (Report, Human Rights and Equal Opportunity Commission, 1993).

‘Mental Health Atlas 2005: Evidence and Research Department of Mental Health and Substance Abuse World Health Organisation’ (Report, World Health Organization, 2005).

‘Mental health policy implementation guide: dual diagnosis good practice guide’; 2002. Department of Health (U.K.)

<http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009058>.

‘Mental Health, Discrimination & Insurance: A Survey of Consumer Experiences 2011’ (Report, Mental Health Council of Australia and Beyondblue, 2011)

<http://www.beyondblue.org.au/index.aspx?link_id=4.62&tmp=FileDownload&fid=2444>.

‘National comorbidity initiative: a review of data collections relating to people with coexisting substance use and mental health disorders’. Cat. No. PHE 60. (Drug Statistics Series No. 14). Canberra: Australian Institute of Health and Welfare; 2005,

<<http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442459660>>.

‘Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems)’ (Policy Paper, Queensland Government, 2008)

<http://www.comorbidity.org.au/sites/default/files/Qld%20DD%20policy%20Oct%2008_0.pdf>.

‘Structural Racism and Community Building’ (Forum Paper, The Aspen Institute Roundtable on Community Change, June 2004)

<http://www.kintera.com/atf/cf/%7BDEB6F227-659B-4EC8-8F848DF23CA704F5%7D/aspen_structural_racism2.pdf>.

Australian Institute of Health and Welfare (AIHW) 2005. Mental health services in Australia 2003–04. AIHW cat no. HSE 40. Canberra: AIHW (Mental Health Series no. 8).

Barclay, Laurie, ‘Integrated Treatment of Substance Use Disorders and Comorbid Conditions - A Literature Review’, *Medscape* (online), 27 April 2009

<<http://www.medscape.com/viewarticle/701725>>.

Brohan, Elaine, *et al.*, 'Experiences of mental illness stigma, prejudice and discrimination: a review of measures' (2010) *BMC Health Services Research* <<http://www.biomedcentral.com/1472-6963/10/80>>.

Clapton, Jayne, and Jennifer Fitzgerald, 'The History of Disability: A History of 'Otherness'' *New Renaissance News* (online), 1997 <<http://www.ru.org/human-rights/the-history-of-disability-a-history-of-otherness.html>>.

DeNavas-Walt, Carmen, Bernadette D Proctor, and Jessica C Smith, 'Income, Poverty, and Health Insurance Coverage in the United States: 2010' (Report No P60-239, United States Census Bureau, September 2011) 56 <<http://www.census.gov/prod/2011pubs/p60-239.pdf>>.

Dicken, John E's letter 31 May 2012 (*United States Government Accountability Office*, Washington) <<http://www.gao.gov/assets/600/591261.pdf>>.

Equal Employment Opportunity Policy to 2010: Future Directions of EEO in the New Zealand Public Service, Appendix 1, Definitions and Key Concepts
<http://www.ssc.govt.nz/node/5282>.

Goren, Netzach, and Jane Mallick 'Prevention and early intervention of coexisting

HREOC (1993) Report of the National Inquiry into the Human Rights of People with Mental Illness,
http://www.hreoc.gov.au/human_rights/mental_illness/national_inquiry.html.

Human Rights Commission, 'A fair go for all? Rite tahi tātou katoa? Addressing Structural Discrimination in Public Services' (Discussion Paper, New Zealand Human Rights Commission, July 2012)
<<http://nhri.ohchr.org/EN/Themes/IndigenousPeoples/DocumentsPage/Addressing%20Structural%20Discrimination%20%20HRC%20New%20Zealand%20Structural%20%282012%29.pdf>>.

Koyanagi, Chris, and Justice David C Bazelon, 'Learning From History: 'Deinstitutionalization of People with Mental Illness as Precursor to Long-Term Care Reform' (Briefing Paper, Kaiser Commission, August 2007).

Link, Bruce G and Jo C Phelan, 'On Stigma and Its Public Health Implications' (Paper presented at On Stigma and Its Public Health Implications, Bethesda Maryland USA, 5 – 7 September 2001) <http://www.stigmaconference.nih.gov/FinalLinkPaper.html>

Mental Health America Attitudinal Survey, 2007
<<http://www.mentalhealthamerica.net/go/go/news/10-year-retrospective-study-shows-progress-in-american-attitudes-about-depression-and-other-mental-health-issues>>.

Mental health and substance use issues, Drug Info Clearing House, Issues Paper 3, November 2007 <
http://www.druginfo.adf.org.au/attachments/347_PRQ03Nov07_final.pdf>.

Merton, Rachel, and Jenna Bateman, 'Social Inclusion: Its Importance to Mental Health' (Research Report, Mental Health Coordinating Council, 2007).

Neasa Martin, 'From Discrimination to Social Inclusion, A review of the literature on antistigma initiatives in mental health' (Literature Review, Queensland Alliance, 2009)
<<http://www.mhcc.org.au/documents/From-discrimination-to-social-inclusion-Lit-review.pdf>>.

Newman, Louise, Submission to the Standing Committee on Finance and Public Administration, *Inquiry into the Council of Australian Governments reforms relating to health and hospitals*, 26 May 2010 < <http://www.ranzcp.org/Files/ranzcp-attachments/Resources/Submissions/sub39-pdf.aspx>>.

Oliver, Kendea Nicole, 'Perceived Stigma and Self-disclosure in Adolescents and Adults Living with Cystic Fibrosis: Measuring the Impact on Psychological and Physical Health.' Master of Arts diss., The Ohio State University, 2011.
<https://etd.ohiolink.edu/ap:10:0::NO:10:P10_ACCESSION_NUM:osu1307639721>.

President John F. Kennedy's remarks on 'Proposed Measures to Combat Mental Illness and Mental Retardation', PUB. PAPERS 137, 138 (Feb. 5, 1963).

Report of the *Review of the Disability Discrimination Act* (Cth) 1992, Productivity Commission, Australian Government, 14 July 2004.
<<http://www.pc.gov.au/projects/inquiry/disability-discrimination/report>>.

Ritch, Alistair Edward Sutherland, '*Sick, Aged and Infirm*' Adults in *The New Birmingham Workhouse, 1852 – 1912* (Thesis for Masters of Philosophy Degree, University of Birmingham, 2009) <http://etheses.bham.ac.uk/846/1/Ritch10MPhil_A1a.pdf>.

Smark, Cirotan, 'Dorothea Dix: A social researcher and reformer' (Working Paper No 06/15, University of Wollongong Faculty of Business - Accounting & Finance, 2006).

Teesson, Maree, and Lucy Burns (eds), 'National Comorbidity Project' (Research Paper, National Drug and Alcohol Research Centre, 2001)
<<http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-publicat-document-metadata-comorbidity.htm>>.

Zigmond, David, 'The Medical Model—its Limitations and Alternatives' (2011) L1 *Physical Culture and Sport Studies and Research* 6 <<http://www.marco-learningssystem.com/pages/david-zigmond/medical-model.htm>>.

D. International law instruments

Convention on the Rights of Persons with Disabilities.

Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.

E. Legislation

Disability Discrimination Act 1992 (Cth).

Guardianship and Administration Act 1995 (Tas).

Mental Health Act 1996 (Tas).

Mental Health Act 2013 (Tas).

Mental Health Parity Act 1996 (U.S.).

Mental Health Parity and Addiction Equity Act 2008 (U.S.)

F. Cases

Disability Advocates, Inc v David A. Paterson, Case 1:03-cv-03209-NGG-MDG Document 341 Filed 09/08/09

G. Media and websites

‘Mental illness and life insurance: What you need to know – a detailed guide’ (Information Sheet, Beyond Blue, Mental Health Council of Australia, Lifewise and the Financial Planning Association, 2010) <<http://www.psychology.org.au/assets/files/mental-illness-and-life-insurance-detailed-guide.pdf>>.

National Alliance on Mental Illness, The Mental Health Parity Act of 1996, <http://www.nami.org/Content/ContentGroups/E-News/1996/The_Mental_Health_Parity_Act_of_1996.htm>

Paulsen, Monte, ‘Canada short changes mental health care: Kirby’, *The Tyee* (online), 22 June 2010 <<http://thetyee.ca/Blogs/TheHook/Health/2010/06/22/Canada-short-changes-mental-health/>>.

Rothman, David, ‘The Rehabilitation of the Asylum’ (2000) *The American Prospect* <<http://prospect.org/article/rehabilitation-asylum>>.

Sullivan. John and Tim Ryan’s letter, ‘Mental Health Parity: Where’s the final rule? October 5, 2012. <<http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/APA%20on%20the%20Issues/09-25-2012-MHPAEA-2012-Letter---DC---FINAL.pdf>>

Wray, Meaghan, ‘There's stigma around the word stigma’ (2012) 139 *The Journal, Queens University* (online) <<http://queensjournal.ca/story/2012-04-05/news/theres-stigma-around-word-stigma/>>.

CHAPTER FOUR

CHALLENGING STIGMA: THE INTERMIX OF POLICY, LAW AND CULTURAL INTERVENTION

1. INTRODUCTION

Stigma is a complex social process associated with competition for power, integrated into the existing social processes of dominance and exclusion.¹ It is an expression of society's intolerance of difference and its rejection of abnormality. Stigma and discrimination are reflections of the complex relationship between the prejudiced attitudes and wrong behaviours, which were discussed in Chapter Three, and both are firmly embedded within the legal system as this chapter shows. Although it may not be immediately apparent as to why much of Chapter Four sits within a thesis concerned with mental illness stigma when it discusses such topics as the law and racism and immigration law, this chapter is crucial to the thesis because it demonstrates how law and governments politicalise language; manipulating its use to achieve, or counter, particular social and political agendas. The chapter is important because it demonstrates how political correctness has, in many areas of social concern, been an effective tool in reducing discrimination, although, not necessarily, prejudice. It shows that the use of 'politically correct' language' is a topical discussion in both the public and legal forums when it relates to issues other than the language associated with mental illness. The chapter is also important because it is contextual to Chapter Five which examines 'sanism' - the specific prejudice, stigma and discrimination associated with mental illness that, according to Perlin, is largely invisible and socially acceptable.²

¹ Bruce G Link and Jo C Phelan, 'Conceptualizing Stigma' (2001) 27 *Annual Review of Sociology* 363. See also Jo Stein, 'HIV/AIDS Stigma: The Latest Dirty Secret' (Working Paper No 46, Centre for Social Science Research University of Cape Town, 2003) <<http://www.heart-intl.net/HEART/010105/HIVAIDSSigmaTh.pdf>>.

² Michael L Perlin, *The Hidden Prejudice: Mental Disability on Trial* (American Psychological Association, 2000).

The academic literature is replete with studies that define, describe, and measure the harmful impact of stigma and discrimination on people's lives.³ The impetus driving this ever enlarging repository of social scientific research is the public health view that diminishing prejudice in the community will cause a concurrent decrease in stigma and discrimination, thereby resulting in an improved quality of life for people who are subjected to stigma and discrimination.⁴ Although there is considerable literature defining and describing stigma, and examining the impact that stigma has on society, there has been little study given⁵ to the complicated process of determining how best to combat stigma.⁶ As shown in the first three chapters, there is little agreement regarding how 'mental illness' is described or understood so that, perhaps expectedly, there are similar vagaries and different, and conflicting ideologies apparent in ascertaining what is the best approach for reducing stigma associated with mental illness.⁷

While the 'best approach' may remain an unknown⁸, the commonly agreed view amongst anti-stigma campaigners is that if a successful, long lasting reduction in stigma is to be achieved, it will require both a top-down approach of change in laws and policies, and a bottom-up approach of improving public empathy and acceptance.⁹ This widely subscribed view emanates from the general confidence that positive attitudes are manifested in well-adjusted behaviours and changing negative behaviours produces positive attitudes, reduces stigma and decreases discrimination. It is this ideal that informs the favoured strategic, three tiered anti-stigma approach that provides the content of this chapter's discussion: (1) the public health approach of raising awareness of stigma and discrimination particularly through educating the public to the belief that mental illness is an 'illness like any

³ Neasa Martin, *From Discrimination to Social Inclusion: A Review of the literature on anti stigma initiatives in mental health*, A Report to the Queensland Alliance, 2009 <<http://www.mhcc.org.au/documents/From-discrimination-to-social-inclusion-Lit-review.pdf>>.

⁴ Patrick W Corrigan and David L Penn, 'Lessons from social psychology on discrediting psychiatric stigma' (1999) 54 *American Psychologist* 765.

⁵ Barbara Everett, 'Stigma: The Hidden Killer' (Background Paper and Literature Review, Mood Disorders Society of Canada, May 2006) <<http://www.mooddisorderscanada.ca/documents/Publications/Stigma%20the%20hidden%20killer.pdf>>.

⁶ Patrick W Corrigan (ed), *On the stigma of mental illness: Practical strategies for research and social change* (American Psychological Association, 2005).

⁷ Neasa Martin, *From Discrimination to Social Inclusion: A Review of the literature on anti stigma initiatives in mental health*, A Report to the Queensland Alliance, 2009 <<http://www.mhcc.org.au/documents/From-discrimination-to-social-inclusion-Lit-review.pdf>>

⁸ Melissa D Pinto-Foltz and M Cynthia Logsdon, 'Reducing Stigma Related to Mental Disorders: Initiatives, Interventions, and Recommendations for Nursing' (2009) 23 *Archives of Psychiatric Nursing* 32.

⁹ Stephen P Hinshaw and Andrea Stier, 'Stigma as Related to Mental Disorders' (2008) 4 *Annual Review of Clinical Psychology* 367.

other; (2) attacking stigma and discrimination through cultural intervention such as political correctness and the enactment of associated sanctioning legislation; (3) and specific performance to remedy discriminatory acts.¹⁰

Chapter Three examined stigma theories, identifying the sociological, psychological and structural forces that create, support and maintain stigma: a phenomenon that consists of a group of three related problems - lack of knowledge/ignorance; negative attitudes/prejudice; and excluding or avoiding behaviours/discrimination.¹¹ Chapter Four demonstrates that these theories are largely theoretical and have limited utilitarian application in achieving a real reduction of stigma.¹² This is shown through the discussion of the three anti-stigma strategies of protest, education and contact that have received the most significant attention in the literature.¹³ Although these strategies were first used in other areas of marginalised difference such as race, gender and sexual orientation, for the most part, they have been unsuccessful. While there has been a decrease in overt, blatant expressions of prejudicial attitudes, a subtle and covert form of negative expression termed 'modern prejudice' has become prevalent.¹⁴ Rather than eliminating prejudice, these anti-stigma strategies appear to have merely suppressed the public's negative attitudes.

Chapter Four analyses first, the limited impact that the public health disease approach, built on its three main anti-stigma strategies; protest, education and contact, has had on stigma reduction. These strategies aim to (1) 'name and shame' unacceptable behaviours in an effort to decrease the likelihood that the behaviour will be repeated; (2) educate the public to facts, disabuse it of myths, and make it aware of the social and economic harms that stigma and discrimination causes, not only to the individual but also to their carers and their communities as a whole; and (3) promote a more inclusive society. It suggests that policy makers wrongly

¹⁰ Fiona Myers *et al.*, 'Evaluation Of 'See Me' - The National Scottish Campaign Against Stigma and Discrimination Associated with Mental Ill-Health' (Scottish Government Social Research, 2009) <http://ec.europa.eu/health/mental_health/eu_compass/reports_studies/seeme_report.pdf>.

¹¹ Everett, above n 5. See also Diana Rose *et al.*, '250 labels used to stigmatise people with mental illness' (Research Paper, British Medical Council Health Services, 2007) <<http://www.biomedcentral.com/content/pdf/1472-6963-7-97.pdf>>.

¹² Heather Stuart, 'Fighting Stigma caused by mental disorders: past perspective, present activities, and future directions' (2008) 7 *World Psychiatry* 185.

¹³ Miriam Heijnders and Suzanne Van Der Meij, 'The fight against stigma: an overview of stigma reduction strategies and interventions' (2006) 11 *Psychology Health and Medicine*, 353.

¹⁴ Anne Pedersen *et al.*, 'Attitudes toward Aboriginal Australians in city and country settings' (2000) 35 *Australian Psychologist* 109.

assumed that once the public was armed with its newly acquired scientific knowledge and social awareness, prejudice would naturally dissipate.

The public health ‘disease like any other’ educational concept has not been effective in changing the cultural context of stigma. By shifting the moral blame for abnormal behaviour from the person to their families (the nature/nurture debate continues to strongly influence current public health policies, research and law) or to science through the disease model, researchers, policymakers, lawyers and mental health professionals believed that the uncontrollable causality of ‘disease’ would generate more compassionate and tolerant public responses. Recent research indicates that the biological emphasis has, in fact, impeded anti-stigma efforts and undermined efforts to change the unsupportive social and physical environments that adversely affect mental health. Although much of the public now accepts the biological aetiology of mental illness, stigma has not diminished and certain forms of stigma and discrimination have actually increased.

This chapter also examines the ideology of ‘political correctness’: an avoidance of forms of expression or actions perceived as excluding, marginalising, or insulting certain social groups. It is a cultural intervention accompanied by regulating and sanctioning anti-discrimination laws. It shows that political correctness is a tool that is selectively used by governments, courts, media and the public to alter society’s informal and formal rules, and manipulate sentiment and opinion to effect change in public thought, language and behaviour. In particular, it examines the role of political correctness in the context of immigration public policy and law which ‘is now the most controversial, and the single largest, area of public law adjudication by courts and tribunals in Australia’.¹⁵

Further, Chapter Four discusses the use of politically correct language in the area of mental health which, as is mostly the case in all aspects of mental health, suffers from the same ambiguities and misinterpretations. While there are problems associated with political correctness in the historical, first wave areas of social concerns such as racism and sexism, Chapter Four shows that unlike mental illness, those problems do not include invisibility and widespread social acceptance. This

¹⁵ McMillan, John, ‘Immigration and the Law Chapter 5 Upholding the Australian Constitution’ (Paper presented at Proceedings of the Fourteenth Conference of The Samuel Griffith Society Sydney, 14 – 16 June, 2002).

chapter shows that on the rare occasion that a matter of offensive language related to mental illness is brought before the courts, the courts are willing to authorise the disrespectful and derogatory language which is a cause, product and validation of stigma.

There is evidence, however, that suggests that certain types of education in combination with contact can have a positive impact on changing prejudicial attitudes, most particularly in young people. This evidence is important to this thesis as it is relevant to the research questions of whether (1) law students are sanist and whether (2) law students who participate in mental health clinical programs founded on therapeutic jurisprudence are less sanist in their attitudes than students that do not participate. Chapter Eight quantitatively examines whether the particular form of education delivered by the Mental Health Tribunal Representation Scheme in conjunction with the direct personal contact students have clients who have a mental illness helps to disabuse them of the myths and stereotypes that were discussed in Chapter Three? It also examines whether the combination of the education, direct personal contact, and the practical skills and personal attributes gained from working with clients who have a mental illness suggests that alumni might contribute to the deconstruction of the legal system's cultural framework of mental illness stigma and discrimination.

The role of Chapter Four is to analyse the ways in which public policy, cultural intervention and law are used to challenge stigma to show that alongside the limited success achieved by the public education strategy, the most employed strategy is the flexible use of 'political correctness' and its accompanying regulating and sanctioning mechanism, anti-discrimination legislation. It will show that while stigma is resistant to change, society is still able to identify offensive and socially unacceptable language and behaviours except, according to Perlin, when it is associated with mental illness.

Perlin's claim raises the question of how society can change its stigmatising and discriminatory language and behaviours when it is unable to recognise them, or has deemed them socially acceptable. Applying this question narrowly to the legal system, the thesis examines one change option in Chapters Seven and Eight. Although the research did not generate sufficient consistent data to enable a

concrete answer to be reached, it did provide valuable information for future research as to whether participation in a therapeutic jurisprudence clinical program can effect positive measurable changes in the attitudes of law students capable of producing stigma and discrimination reductions in the legal system.

2. LAW AND PUBLIC HEALTH

With the clear aim of challenging the complex, multilayered phenomenon that is stigma, changing the public's attitudes towards mental illness and eliminating discriminatory behaviours, policy makers have largely been influenced by the industry of stigma change research¹⁶ that favours implementing large scale, broad based programs, founded on a multi-pronged approach of the three tier stigma reducing strategies. These are protest, education and contact.¹⁷ The presumption underlying this approach is that the expression of negative attitudes leads to discriminatory behaviours and so the solution is to ensure that people will not do negative things by creating positive attitudes. 'The lack of evidence for this proposition deters no one'.¹⁸ Most recently, Pescosolido found the individuals were more willing to express stigma than to act on it.¹⁹ Some researchers have suggested that while attitudes are important, attitudinal change is unnecessary for behavioural change and that if prejudice and discrimination are to be reduced then the most attention should be paid to effecting behavioural changes.²⁰

¹⁶ Jo C Phelan *et al.*, 'Public conceptions of mental illness in 1950 and 1996: what is mental illness and is it to be feared?' (2000) 41 *Journal of Health and Social Behavior* 188.

See also Anthony F Jorm *et al.*, 'Mental health literacy: A survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment' (1997) 166 *Medical Journal of Australia* 182. See also Anthony F Jorm, Helen Christensen and Kathleen M Griffiths, 'The impact of beyondblue: the national depression initiative on the Australian public's recognition of depression and beliefs about treatments' (2005) 39 *Australian and New Zealand Journal of Psychiatry* 248. Also Catherine Francis *et al.*, 'Improving Mental Health Literacy: A Review of the Literature' (Literature Review, Centre for Health Program and Evaluation Evidence, June 2002)

<[http://quitnow.gov.au/internet/main/publishing.nsf/Content/6A5554955150A9B9CA2571FF0005184D/\\$File/li teracy.pdf](http://quitnow.gov.au/internet/main/publishing.nsf/Content/6A5554955150A9B9CA2571FF0005184D/$File/li teracy.pdf)>.

¹⁷ Patrick W Corrigan and Amy C Watson, 'Understanding the impact of stigma on people with mental illness' (2002) 1 *World Psychiatry* 16, 16.

¹⁸ Harris Chaiklin, 'Attitudes, Behaviour, and Social Practice' (2011) 38 *Journal of Sociology and Social Welfare* 31, 46.

¹⁹ Bernice A Pescosolido *et al.*, 'The "Backbone" of Stigma: Identifying the Global Core of Public Prejudice Associated With Mental Illness' (2013) 103 *American Journal of Public Health* 853.

²⁰ Chaiklin, above n 18, 48.

2.1 Protest strategy

Protest is a punishing strategy whereby injustices are highlighted and offenders chastised for their stereotyping and discriminations in the hope that their behaviour will not be repeated.²¹ It is meant to change behaviour, not attitudes²² although some commentators argue that behaviour is a direct attitude manifestation.²³ While there is some evidence to suggest that protest positively influences harmful behaviours, it has largely been anecdotal,²⁴ with the weight of empirical evidence suggesting that protest campaigns are ineffective in changing attitudes,²⁵ and may in fact, make attitudes worse.²⁶ Trying to coerce attitudinal change can also reinforce discriminatory behaviour.²⁷ Penn found that ‘stereotype suppression may have modest, although limited effects, on psychiatric stigma’²⁸ but it had no impact on the behaviours directed toward people experiencing a severe mental illness.²⁹ Telling people to stop believing in their negative beliefs about mental illness, or to ignore or suppress their negative thoughts or attitudes could have a paradoxical rebound effect with stigmatisation being augmented rather than reduced.³⁰ The cognitive process of avoiding unwanted thoughts may, through concentration, allow the thought to achieve a level of accessibility that exceeds normal levels of accessibility to the extent that the unwanted thoughts may exert a measure of influence on a person’s thoughts, and possibly behaviour, greater than if there had been no attempt at suppression.³¹

²¹ Patrick W Corrigan and Jenessa R Shapiro, ‘Measuring the Impact of Programs that Challenge the Public Stigma of Mental Illness’ (2010) 30 *Clinical Psychology Review* 907.

²² Patrick W Corrigan, David Roe and Hector W H Tsang, *Challenging the Stigma of Mental Illness: Lessons for Therapists and Advocates* (John Wiley and Sons, 2011).

²³ Terry M Dockery and Arthur G Bedesian, ‘Attitude versus actions: LaPiere’s (1934) classic study revisited’ (1989) 17 *Social Behavior and Personality* 9.

²⁴ Otto E Wahl, *Media Madness: Public images of mental illness* (Rutgers University Press, 1995).

²⁵ Patrick W Corrigan *et al.*, ‘Three strategies for changing attributions about severe mental illness’ (2001) 27 *Schizophrenia Bulletin* 187.

²⁶ David L Penn and Patrick W Corrigan, ‘The effects of stereotype suppression on psychiatric stigma’ (2002) 55 *Schizophrenia Research* 269.

²⁷ Chaiklin, above n 18.

²⁸ David L Penn and Shannon M Couture, ‘Strategies for reducing stigma toward persons with mental illness’ (2002) 1 *World Psychiatry* 20, 20.

²⁹ *Ibid* 21.

³⁰ Margo J Monteith, Jeffrey W Sherman and Patricia G Devine, ‘Suppression as a stereotype control strategy’ (1998) 2 *Personality and Social Psychology Review* 63.

³¹ *Ibid*, 65.

Protest campaigns have long been used as weapons by weak social groups for influencing policy and legislative changes³² but these changes do not automatically translate into changing attitudes and social practices³³ and although behaviours might change, values and norms are likely to remain unchanged.³⁴ A prominent Australian protest campaign is Stigma Watch, a Sane Australia³⁵ initiative that offers an online forum for mental health consumers and supporters to report ‘inappropriate news stories, commentary, advertisements or products’.³⁶ It claims that it is ‘helping to change community attitudes’³⁷ by ‘making it known that stigma won’t be tolerated’³⁸ but a critical aspect of rights-based protest campaigns is that they do not require attitudinal change.³⁹ The aim of protest campaigns is to change behaviours but the education strategy discussed below aims to change attitudes.

2.2 Education strategy

Stigma was expected to abate with increased knowledge of mental illness, but just the opposite occurred: stigma in some ways intensified over the past 40 years even though understanding improved.⁴⁰

The wealth of scientifically supportable evidence detailing the harmful effects of stigma prompted the propagation of public health campaigns with the specific intent of altering the public’s negative attitudes by improving its mental health literacy.⁴¹ A prominent finding in the 1990s suggested that negative attitudes were fuelled by a lack of knowledge, and that ignorance was the predicator of prejudice.⁴² The general presumption behind this strategy is that if the public’s negative attitudes are

³² Richard Roberts, ‘Shaming, State Power, and Enforcement in the History of Anti-Trafficking Efforts: African Perspectives’ (Working Paper No 006, Program on Human Rights Centre on Democracy, Development, and the Rule of Law, June 2012) <http://iis-db.stanford.edu/pubs/23749/Roberts_Shaming_Final_06_13_13.pdf>.

³³ David J Hunter and Amanda Killoran, ‘Tackling health inequalities: turning policy into practice?’ (Health Development Agency, 2004). <<http://www.nice.org.uk/nicemedia/documents/tacklinghealthinequalities.pdf>>.

³⁴ Roger Giner-Sorolla *et al.*, ‘Shame expressions reduce the recipient’s insult from outgroup reparations’ (2008) 44 *Journal of Experimental Social Psychology* 519.

³⁵ SANE Australia was founded in 1986 and is a national charity working for a better life for people affected by mental illness – through campaigning, education and research. <<http://www.sane.org/information/about-sane>>.

³⁶ *Ibid.*

³⁷ *Ibid.*

³⁸ *Ibid.*

³⁹ Michael Smith, ‘Stigma’ (2002) 8 *Advances in Psychiatric Treatment* 317.

⁴⁰ Mental Health, Report of the Surgeon General, 1999 <<http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBHS>>

⁴¹ The term was introduced by Anthony F Jorm *et al.*, ‘Mental health literacy’: a survey of the public’s ability to recognise mental disorders and their beliefs about the effectiveness of treatment’ (1997) 167 *Medical Journal of Australia* 182.

⁴² Geoffrey Wolff *et al.*, ‘Community Knowledge of Mental Illness and Reaction to Mentally Ill People’ (1996) 168 *The British Journal of Psychiatry* 191.

positively changed, stigma will reduce and discrimination will decrease.⁴³ The ideal that positive attitudes manifest in well-adjusted actions has dominated public health policy but despite the unprecedented volume of factual biomedical information that has been delivered into the public arena,⁴⁴ the level of accurate knowledge about mental illnesses continues to remain meagre⁴⁵ and the widespread reduction in stigma has not occurred.⁴⁶ This may be because as some commentators suggest, stigma emanates from social inequality not social ignorance.⁴⁷

Yet public health systems continue to wholeheartedly accept the premise that ignorance is the key factor in the perpetuation of stigma⁴⁸ and that 'If there is a causal relationship between lack of knowledge or experience of the mentally ill and negative attitudes, it may well be that an educational intervention will improve attitudes ...'⁴⁹ Education challenges inaccurate stereotypes and replaces them with factual scientific information. People who possess more factual information about mental illness are believed to be less likely to stigmatise than people who are misinformed,⁵⁰ however, it appears that the delivery of factual information has been more effective in reducing the stigma associated with a serious mental illness in general than reducing stigma directed toward individuals who experience a severe mental illness.⁵¹

A number of potential problems have been identified with the education strategy. First, it contributes to the minimisation of the impact that social and environmental factors have on mental health. If three out of four people can deal with divorce, bereavement, debt, unemployment, homelessness without becoming 'mentally ill',

⁴³ Ian F Brockington, Peter Hall, Jenny Levings and Christopher Murphy, 'The community's tolerance of the mentally ill' (1993) 162 *British Journal of Psychiatry* 93.

⁴⁴ Patrick W Corrigan *et al.*, 'Mental illness stigma: problem of public health or social justice?' (2005) 50 *Social Work* 363.

⁴⁵ Graham Thornicroft *et al.*, 'Stigma: ignorance, prejudice or discrimination?' (2007) 190 *The British Journal of Psychiatry* 192. See Arthur Crisp *et al.*, 'Stigmatization of people with mental illnesses: a follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists' (2005) 4 *World Psychiatry* 106.

⁴⁶ Robert A Hayes and Christopher Vaughan, 'Stigma directed toward chronic illness is resistant to change through education and exposure' (2002) 90 *Psychology Reporter* 1161.

⁴⁷ Link and Phelan, above n 1. See also Jo Stein, 'HIV/AIDS Stigma: The Latest Dirty Secret' (Working Paper No 46, Centre for Social Science Research University of Cape Town, 2003) <<http://www.heart-intl.net/HEART/010105/HIVAIDSSigmaTh.pdf>>.

⁴⁸ Smith, above n 39.

⁴⁹ Wolff *et al.*, above n 42, 196.

⁵⁰ Corrigan and Penn, above n 4.

⁵¹ David L Penn and Bruce Link, 'Dispelling the stigma of schizophrenia, III: The role of target gender, laboratory-induced contact, and factual information' (2002) 6 *Psychiatric Rehabilitation Skills* 255.

the three will question why the fourth can't do the same.⁵² Society asks why they don't just 'pull their socks up', 'get on with it' and 'stop putting it on' like everyone else does. This commonly shared viewpoint is promoted by the media, which reports, for example, that depression is the 'latest must-have accessory' for middle-class women.⁵³

Secondly, it confuses the frequency of common mental illnesses with the fair treatment of people experiencing the uncommon, severe mental illnesses. Acceptance rather than equality underlies most education campaigns including Australia's 'Beyond Blue', the United Kingdom's 'Changing Minds' and New Zealand's 'Like Minds, Like Mine' all of which promote people experiencing mental illness as being 'just like us' except that they have a genetic or medical difference.⁵⁴ The rationale behind these anti-stigma campaigns that say little or nothing about the severity and difficulties associated with serious mental illnesses, especially anything associated with psychosis or news headline incidents of violence, is to create a general acceptance of mental illness and a much more positive outlook surrounding recovery.⁵⁵ The indirect consequence of this strategy is that it further marginalises serious mental illness because as a topic, it is made publically unpalatable yet it is people who experience serious mental illness and are characterised as 'definitely not like us' who most often come to the attention of the legal system.

Thirdly, recent research has found that the framing of mental illness in biological terms has led to the paradoxical effect⁵⁶ of increasing the public's negative attitudes about mental illness.⁵⁷ The disease model amplifies the distinction between 'them and us', making 'them' an 'almost a different species.'⁵⁸ Families are equally subjected to mental illness stigma because of their shared genetic, biological

⁵² 'Cosmetic anti-stigma campaigns miss the point' (2012) 4 *NSSS Advocacy Bulletin*

<<http://www.northshoreschizophrenia.org/images/2012%20Feb%20Advocacy%20Bulletin.pdf>>.

⁵³ Janet Street Porter, 'Depression? It's just the new trendy illness!', *Daily Mail Online* (online), 5 August 2010 <<http://www.dailymail.co.uk/debate/article-1278510/Depression-Its-just-new-trendy-illness.html>>.

⁵⁴ Carolyn Shimmin, 'Understanding stigma through a gender lens' (2009) 11 *Canadian Women's Health Network* 14.

⁵⁵ 'Cosmetic anti-stigma campaigns miss the point' above n 52.

⁵⁶ Jo C Phelan, Rosangely Cruz-rojas and Marian Reiff, 'Genes and Stigma: The Connection Between Perceived Genetic Etiology and Attitudes and Beliefs About Mental Illness' (2002) 6 *Psychiatric Rehabilitation Skills* 159.

⁵⁷ Sheila Mehta and Farina Amerigo, 'Is Being "Sick" Really Better? Effect of the Disease View of Mental Disorder on Stigma' (1997) 16 *Journal of Social and Clinical Psychology* 405.

⁵⁸ *Ibid* 416.

attributions.⁵⁹ Once labelled ‘mentally ill’, it is extremely difficult to detach from the label, no matter how many years the individual may have been symptom/sign free.⁶⁰ The permanency of the label is likely due to the perception that mental illness is a stabile problem⁶¹ which contributes to the public pessimism that a person can never truly recover from mental illness. This belief is perpetuated by the legal system in which evidence of past mental illness is usually a key factor in a variety of present legal circumstances where mental illness is an issue such as family law children’s matters, obtaining insurance coverage, determining the validity of a will or contract, providing a defence to criminal charges or holding a position on a Board of Directors.

Fourthly, the stigma associated with mental illness is exacerbated by the disease model’s associations of instability, unpredictability and uncontrollability that fuel the public’s fear of violence and genetic contamination.⁶² People experiencing a mental illness are perceived as having no control over the unacceptable and potentially dangerous behaviours that manifest, just as they had no control about the onset of their illness. Research shows that people who endorse biological causal beliefs appear to be more likely to agree with negative perceptions of people experiencing mental illness as being dangerous, antisocial, and unpredictable,^{63 64 65} and as a rule, people who stigmatise are the least likely to want to undertake education to change their negative attitudes.⁶⁶ Being confronted with factual ‘truths’ and being told that their long held and deeply felt beliefs are groundless is not likely to result in their prejudicial ideas vanishing. Social intelligence and social tolerance are not adjuncts to information delivery.

Contrary to the general appeal of education as a cure all for the most varied of social problems, ‘public education does not destroy prejudice and discrimination in

⁵⁹ Jo C Phelan, ‘Genetic bases of mental illness – a cure for stigma?’ (2002) 25 *Trends in Neurosciences* 430.

⁶⁰ Ibid 431.

⁶¹ Edward E Jones *et al.*, *Social Stigma: The Psychology of Marked Relationships* (W.H. Freeman, 1984).

⁶² Ibid.

⁶³ John Read and Alan Law, ‘The relationship between causal beliefs and contact with users of mental health services to attitudes to the ‘mentally ill’’ (1999) 45 *International Journal of Social Psychiatry* 216.

⁶⁴ John Read and Niki Harre, ‘The role of biological and genetic causal beliefs in the stigmatisation of ‘mental patients’’ (2001) 10 *Journal of Mental Health* 223.

⁶⁵ Jason Schnittker, ‘An uncertain revolution: Why the rise of a genetic model of mental illness has not increased tolerance’ (2008) 67 *Social Science and Medicine* 1370.

⁶⁶ Peter Byrne, ‘Stigma of mental illness and ways of diminishing it’ (2000) 6 *Advances in Psychiatric Treatment* 65.

the community’⁶⁷ and generally, the ‘[y]ears of research into public attitudes and stigma have not led to the development of effective models of change’.⁶⁸ A recent comparative study suggests that despite the anticipated advances in public knowledge, stigma has remained surprisingly fixed.⁶⁹ The single large-scale, broad-based mass campaigns that policy-makers tend to develop have done little to reduce the stigma associated with mental disorders⁷⁰ although some campaigns have succeeded in reducing stigma associated with depression.⁷¹ These campaigns have proved much less successful than campaigns that tailor the content of the message to target specific groups.⁷² There is also more potential for achieving positive mental attitudinal change from short term campaigns.⁷³ Continuing with the current global approach to disseminating a disease model barrage of information rather than designing small, localised programs to tackle particular attitudes of specific groups toward mental illness⁷⁴ will not result in a decrease in stigma but will, as the evidence suggests, continue its pervasiveness and increase its incidence.⁷⁵

Although ‘the impact of education may be limited’⁷⁶ there is sufficient evidence to suggest that participation in brief courses on mental illness⁷⁷ can improve attitudes⁷⁸

⁶⁷ Robert K Merton, ‘The Self-Fulfilling Prophecy’ (1948) 8 *The Antioch Review* 193.

⁶⁸ ‘Discrimination against people with experiences of mental illness’ (Discussion Paper, Mental Health Commission, July 1997) 16
<<http://www.hdc.org.nz/media/200685/discrimination%20against%20people%20with%20experiences%20of%20mental%20illness%20july%202007.pdf>>.

⁶⁹ Bernice A Pescosolido *et al.*, ‘“A disease like any other”? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence’ (2010) 167 *American Journal of Psychiatry* 1321, 1325. See also Georg Schomerus *et al.*, ‘Evolution of Public Attitudes about Mental Illness: A Systematic Review and Meta-Analysis’ (2012) 125 *Acta Psychiatrica Scandinavica* 440. See also Andrew R Payton and Peggy A Thoits, ‘Medicalization, Direct-to-Consumer Advertising, and Mental Illness Stigma’ (2011) 1 *Society and Mental Health* 55.

⁷⁰ Beate Schulze and Matthias C Angermeyer, ‘Subjective experiences of stigma. A focus group study of schizophrenic patients, their relatives and mental health professionals’ (2003) 56 *Social Science & Medicine* 299.

⁷¹ Ulrich Hegerl and Lisa Wittenburg, ‘Focus on mental health care reforms in Europe: the European alliance against depression: a multilevel approach to the prevention of suicidal behaviour’ (2009) 60 *Psychiatric Services* 596.

⁷² Patrick W Corrigan, ‘Where Is the Evidence Supporting Public Service Announcements to Eliminate Mental Illness Stigma?’ (2012) 63 *Psychiatric Services* 79. See Also Claire M Kelly, Anthony F Jorm and Annemarie Wright, ‘Improving mental health literacy as a strategy to facilitate early intervention for mental disorders’ (2007) 187 *Medical Journal of Australia* S26. Also Patrick W Corrigan, ‘Target-specific stigma change: A strategy for impacting mental illness stigma’ (2004) 28 *Psychiatric Rehabilitation Journal* 113.

⁷³ Sara Evans-Lacko *et al.*, ‘Evaluation of a brief anti-stigma campaign in Cambridge: do short-term campaigns work?’ (2010) 10 *Biomed Central Public Health* 1.

⁷⁴ Corrigan, above n 72. See also Petrus Ng and Kai-Fong Chan, ‘Attitudes towards people with mental illness, Effects of a training program for secondary school students’ (2002) 14 *International Journal of Adolescent Medical Health* 215, 222 – 223.

⁷⁵ E Fuller Torrey, ‘Stigma and Violence: Isn’t It Time to Connect the Dots?’ (2011) 37 *Schizophrenia Bulletin* 892.

⁷⁶ Paul E Holmes *et al.*, ‘Changing attitudes about schizophrenia’ (1999) 25 *Schizophrenia Bulletin* 447, 454.

⁷⁷ Ibid 456. See also J K Morrison, J J Cocozza, and D Vanderwyst, ‘An attempt to change the negative, stigmatizing image of mental patients through brief re-education’ (1980) 47 *Psychological Reports* 1, 334.

⁷⁸ Patrick Corrigan, ‘How Stigma Interferes With Mental Health Care’ (2004) 59 *American Psychologist* 614.

particularly the attitudes of young people.⁷⁹ This finding is important to this thesis and the discussion on changing the attitudes of law students undertaken in later chapters. Studies evaluating the impact of these types of short programs have been consistent in the result that ‘educational workshops with young people can have a small but positive impact on students' views of people with mental health problems’⁸⁰ although there is evidence to suggest that the positive impact may not be long lasting.⁸¹ There is a need for future research to determine how these minimal, positive changes can be maintained over time.⁸² The research undertaken in this thesis suggests that reducing stigma amongst law students and ultimately decreasing discrimination in the legal system requires that the short course mental health education is founded on a therapeutic jurisprudence model, and is delivered in unison with a program of personal contact with people who experience mental illness.

2.3 Contact

The third strategy with an expected outcome of decreasing prejudicial attitudes and behaviours is contact. Contact promotes increased interpersonal interaction between the general population and people experiencing mental illness.⁸³ Chaiklin suggests that creating interaction situations is the way to deal with negative stereotypes but it should not be used to try to change attitudes.⁸⁴ When directly compared against educational and protest programs, contact, when used in carefully controlled trials, has been shown to effect improvement in attitudes.⁸⁵ Yamaguchi’s review found that when comparing the three types of interventions, direct contact appeared key to stigma reduction.⁸⁶ One of the problems identified with the research, however, is

⁷⁹ Amy C Watson, ‘Changing Middle Schoolers' Attitudes About Mental Illness Through Education’ (2004) 30 *Schizophrenia Bulletin* 563. See also Petrus Ng and Kai-Fong Chan, ‘Attitudes towards people with mental illness. Effects of a training program for secondary school students’ (2002) 14 *International Journal of Adolescent Medical Health* 215.

⁸⁰ Vanessa Pinfold *et al.*, ‘Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools’ (2003) 182 *The British Journal of Psychiatry* 342, 344.

⁸¹ Mary Keane, ‘Acceptance vs. rejection: nursing students' attitudes about mental illness’ (1991) 27 *Perspectives in Psychiatric Care* 13. See also Vanessa Pinfold *et al.*, ‘Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools’ (2003) 182 *The British Journal of Psychiatry* 342, 344.

⁸² Holmes *et al.*, n 76.

⁸³ Corrigan and Shapiro, above n 21.

⁸⁴ Chaiklin, above n 18, 45.

⁸⁵ Corrigan and Shapiro, above n 21, 910.

⁸⁶ Sosei Yamaguchi, Yoshio Mino and Shahir Uddin, ‘Strategies and future attempts to reduce stigmatization and increase awareness of mental health problems among young people: a narrative review of educational interventions’, (2011) 65 *Psychiatry and clinical neurosciences* 405.

that there has been little study given to understanding how contact changes stigma prospectively.⁸⁷

Chapter Eight examines the contact strategy in more detail. It compares the attitudes of law students who have undertaken mental health awareness training, and represented clients appearing before the Mental Health Tribunal, with the attitudes of law students who have not. Overall, the results of the study provide some valuable empirical insight in understanding the stigmatising attitudes of law students. It is hoped that the findings will contribute to future research into the development of strategies aimed at reducing stigma and discrimination associated with mental illness in the legal system to the advantage of a very vulnerable group of legal service users.

3. THE LAW AND THE DISEASE MODEL

We must make it clear, once and for all: mental illness is no different from physical illness.

President Clinton
White House Conference on Mental Health
June 7, 1999⁸⁸

As shown in the previous chapters, mental illness is viewed from a number of different theoretical perspectives including biological, psychological, environmental and social. There are two perspectives that presently dominate mental health discussion. The first, the biological, characterises mental disorders as malfunctions of the body such as abnormal brain structure, genetics and neurotransmitter dysregulation. The second is the psychosocial, which although it does not discount biological causation, focuses on identity, characterising mental disorders as being caused or influenced by life experiences as well as maladjusted cognitive and behaviour processes such as trauma, bad parenting and life stresses.⁸⁹

This section examines how anti-stigma campaigns have attempted to re-educate the public by replacing stigmatising perceptions of moral causation and personal

⁸⁷ Monika E Kolodziej and Blair T Johnson, 'Interpersonal contact and acceptance of persons with psychiatric disorders: a research synthesis' (1996) 64 *Journal of Consulting and Clinical Psychology* 387.

⁸⁸ The White House at Work, The Clinton-Gore Administration: Addressing Mental Health, Monday, June 7, 1999 <<http://clinton2.nara.gov/WH/Work/060799.html>>

⁸⁹ Lauren B Alloy, John H Riskind, Margaret J Manos, 'Abnormal psychology: current perspectives' (9th ed, McGraw-Hill, 2005).

responsibility for a ‘weak will’ and ‘bad character’ with an acceptance of scientific and environmental causes that place mental illness outside the person’s control. It examines the nature/nurture debate which continues to have a pervasive influence on research in areas such as biology, neuroscience, child development and criminology despite, as some critics argue, modern biology having made the distinction between nature and nurture obsolete as any given set of genes has different effects in different environments.⁹⁰ The nature argument recently gained support from the advancements made in neuroscience technology which make it possible to identify structural anomalies in the brain. This evidence is increasingly being used by courts, and particularly the criminal courts to guide their determinations,⁹¹ a trend more fully discussed in 3.8 below.

While the legal system broadly accepts the disease model’s manifesto that mental illness is outside an individual’s control and therefore should not be blamed, the family courts continue to hand down decisions that are reflective of moral blame/weakness of character in matters involving children and parents with a mental illness. This is made evident in Chapter Six’s examination of recent Australian family law parenting order decisions. However, the legal system is selective in its support of the disease model. It is prepared to discount medical evidence when if it did not, the court believes that the outcome would be morally unpalatable. This selectivity is an indicator of deeply entrenched stereotypes such as the belief that ‘mentally ill’ parents are ‘bad parents’.

3.1 Shifting the blame

Researchers, policymakers and mental health professionals assumed that knowledge of uncontrollable causality and the absence of responsibility would elicit emotional responses of sympathy, pity and compassion.⁹² If mental illness could be made comparable in the public mind to Alzheimer’s disease for example, blame, anger and social avoidance would decrease.⁹³ It simply requires an acceptance of socially

⁹⁰ Steven Pinker, ‘Why nature & nurture won’t go away’ (2004) 133 *Daedalus* 5, 7.

⁹¹ Walter Sinnott-Armstrong *et al.*, ‘Brain Images as Legal Evidence’ (2008) 5 *Episteme* 359.

⁹² Bernard Weiner, *Judgments of Responsibility: A Foundation for a Theory of Social Conduct* (Guilford Press, 1995) 20.

⁹³ Mental illnesses are ‘illnesses just like any other: heart disease, diabetes, asthma. Yet the traditions of flowers, sympathy and support provided to people with a physical illness are often denied to those with a mental illness’. ‘What is mental illness?’, Department of Health and Ageing, Australian Government website, <<http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-w-whatmen-toc~mental-pubs-w-whatmen-myth>>

unacceptable behaviours as manifestations of an illness that is a ‘disease like any other’.⁹⁴ The moral ‘blame’ for the abnormal behaviour would shift from the individual to the science of mental illness: ‘brain blame’.⁹⁵

The U.S. Congress declared the decade beginning January 1, 1990 as the Decade of the Brain.⁹⁶ Thus began a global campaign to enhance public awareness as to the benefits to be derived from brain research. In conjunction with the resolution, the U.S. Surgeon General issued a landmark report on mental health in 1999 which explained that if the conditions of the mind could be better explained by a scientific ‘cause-and-effect’ relationship, then the stigma associated with mental illness would wane.⁹⁷ The normal emotional response toward any person judged responsible for a negative life situation is to attribute blame.⁹⁸ It is a habitual response⁹⁹ that leads to anger and social avoidance.¹⁰⁰ The assumption was that if the person was perceived as a victim of a biological disorder beyond their control, they would not be blamed for their condition, or its symptoms.¹⁰¹ However, studies show that the like-minded belief that mental illness is about weak people making bad choices still persists, and that the people who believe that mental illness is caused by ‘weak wills’ and ‘bad character’ are more inclined to stigmatise.¹⁰²

In deciding legal issues of competency or capacity, courts rely on the opinions of mental health experts who are given broad leeway to express their opinions about the ultimate issue before the court.¹⁰³ The psychiatric way has been, and continues to be regarded by the moral authorities as the only way because it is viewed as the

⁹⁴ Dale L Johnson, ‘Schizophrenia as a brain disease: implications for psychologists and families’ (1989) 44 *American Psychologist* 553.

See also Patrick W Corrigan, Fred E Markowitz and Amy C Watson, ‘Structural levels of mental illness stigma and discrimination’ (2004) *Schizophrenia Bulletin* 481.

⁹⁵ David H Barlow and Vincent M Durand, *Abnormal Psychology: An Integrative Approach* (Wadsworth Cengage Learning, 2011) 569.

⁹⁶ House Joint Resolution 174.

⁹⁷ Mental Health, Report of the Surgeon General, 1999

<<http://www.surgeongeneral.gov/library/mentalhealth/chapter1/sec1.html>>

⁹⁸ Weiner, above n 92, 16.

⁹⁹ Daniel N Robinson, *Praise and Blame* (Princeton University Press, 2002) 7.

¹⁰⁰ Weiner, above n 92, 16.

¹⁰¹ Reuven Bar-Levav, ‘The stigma of seeing a psychiatrist’ (1976) 30 *American Journal of Psychotherapy* 473. See also Richard A Schwartz and Ilze K Schwartz, ‘Reducing the stigma of mental illness’ (1977) 38 *Diseases of the Nervous System* 101.

¹⁰² Matthias C Angermeyer and Herbert Matschinger, ‘Causal beliefs and attitudes to people with schizophrenia: Trend analysis based on data from two population surveys in Germany’ (2005) 186 *British Journal of Psychiatry* 331.

¹⁰³ Matthew Large, Olav Nielssen and Gordon Elliott, ‘Reliability of psychiatric evidence in serious criminal matters: fitness to stand trial and the defence of mental illness’ (2009) 43 *Australian and New Zealand Journal of Psychiatry* 446.

way of scientific truth. Despite it being shown in Chapter Two that there is very little science and very little ‘truth’ in psychiatry,¹⁰⁴ it is psychiatric opinion that informs the legal system. After more than a century of psychiatry and psychology’s acceptance of theoretical models that have had poor family socialisation and individual character weakness as central to the genesis of mental illness, stigmatisation became embedded in the core of the helping disciplines.¹⁰⁵ Mental illness has long been considered the domain of the weak willed and morally defective,¹⁰⁶ a perception that appears to have been little altered by the ‘brain blame’ paradigm.

3.2 Nurture

In the first half of the 20th century, psychiatry embraced the ideas and teachings of Sigmund Freud, founder of the psychoanalytic school of psychiatry.¹⁰⁷ Prior to Freud’s revolutionary theories on the nature and functioning of the unconscious mind, a form of positivism had existed in which it was believed that a person only needed to make the choice to act in the right way and live a moral life informed by religion, or a rational life informed by science. This positivist approach never entirely lost its appeal to psychiatry as is evidenced in the classification of homosexuality as a mental disorder up until the 1970s.¹⁰⁸

Freud’s theory that pathogenic parental care was responsible for the development of certain mental illnesses¹⁰⁹ shifted the ‘control’, and therefore the ‘blame’ away from the individual. It began the psycho/social era of ‘there are no bad children, only bad parents’. Health professionals and social workers were trained to view children as mere products of their environment: intrinsically good children were influenced to be otherwise through pathogenic parenting.¹¹⁰ Ostensibly, this era has passed

¹⁰⁴ Thomas S Szasz, ‘The Lying Truths of Psychiatry’ (1979) 3 *The Journal Of Libertarian Studies* 121. See also Els van Dongen and Sylvie Fainzang (eds), *Lying and Illness: Power and Performance* (Het Spinhuis, 2005).

¹⁰⁵ Hinshaw and Stier above n 9.

¹⁰⁶ Angela K Thachuk, ‘Stigma and the politics of biomedical models of mental illness’ (2011) 4 *International Journal of Feminist Approaches to Bioethics* 140.

¹⁰⁷ Volker Hess and Benoît Majerus, ‘Writing the history of psychiatry in the 20th century’ (2011) 22 *History of Psychiatry* 139.

¹⁰⁸ Robert L Spitzer, ‘The diagnostic status of homosexuality in DSM-III: a reformulation of the issues’ (1981) 138 *American Journal of Psychiatry* 210.

¹⁰⁹ Robert B. Ewen, *An Introduction to Theories of Personality*, (Lawrence Erlbaum and Associates, 2003)

¹¹⁰ Michael Rutter, ‘Maternal Deprivation Reconsidered’ (1972) 16 *Journal of Psychosomatic Research* 241, 241.

although the belief in nurture blame can still be found in current social campaigns such as ‘Violence is a Learned Behaviour’.¹¹¹

Cohen discounted parental responsibility for mental illness and emotional problems in children, arguing that genetic influences were more powerful than the influence of either good parenting or bad parenting.¹¹² Understandably, the genetic/disease model found strong support amongst the ‘blamed’ families who have, in recent decades, evolved into politically powerful advocacy organisations, advising and influencing governments on mental health policies.¹¹³

3.3 Nature

The campaign to change the public’s causal perceptions from moralistic ‘poor choices’ and ‘weak wills’ to mental illness being ‘an illness like any other’ resulted in a flood of evidence based research supporting biochemical, neurological and genetic causations. This evidence, strongly suggesting that genetic predispositions underlie many of the major mental disorders, is said to have been responsible for the reascension of the medical model of mental illness.¹¹⁴ Although there has been keen academic debate arguing that the terms ‘illness’ and ‘disease’ do not necessarily imply a biological cause exclusively, the impetus for the promotion of ‘mental illness is an illness like any other’ is based precisely on such an implication.¹¹⁵

3.4 Normalisation

There has been growing agreement amongst mental health professionals that the experience of mental illness is a common part of the human experience and so it

¹¹¹ ‘Domestic Violence is about power and control over another person. It is not a problem with anger. Rarely do you see an abuser act violently with friends, coworkers or a boss. It is a Jeckyl and Hyde personality that confuses others who learn of a person’s violence with their partners. Abusers can act charming, loving and attentive...when they want to. Drinking, drugs, genetics, the victim’s behavior or stress does not cause domestic violence. It is learned behavior. It is learned in the home by observation and reinforcement before the age of 10.’ <http://www.fresno.courts.ca.gov/family/domestic_violence_issues.php>

¹¹² David B Cohen, *Stranger in the Nest: Do Parents Really Shape Their Child's Personality, Intelligence, or Character* (John Wiley and Sons, 1999).

¹¹³ Michelle Funk *et al.*, ‘Advocacy for mental health: roles for consumer and family organizations and governments’ (2006) 21 *Health Promotion International* 70. See also Robert Sommer, ‘Family advocacy and the mental health system: The recent rise of the alliance for the mentally ill’ (1990) 61 *Psychiatric Quarterly* 205.

¹¹⁴ Theodore P Beauchaine and Stephen P Hinshaw (eds), *Child and Adolescent Psychopathology* (Wiley, 2008).

¹¹⁵ John Read, ‘Why promoting biological ideology increases prejudice against people labelled “schizophrenic”’ (2007) 42 *Australian Psychologist* 118, 118.

should be normalised.¹¹⁶ Anti-stigma campaigners have attempted to ‘normalise’ mental illness by promoting the statistic that 1 in 4 people¹¹⁷ or 1 in 5¹¹⁸ people will experience a mental illness, a statistical consequence of the ‘medicalisation of life’ discussed in Chapter Two. Anti-stigma campaigns have tended to focus on socially relatable mental health problems such as sadness, irritability, loss of energy or motivation, anxiety and the depressed feelings when a loved one dies or a marriage breaks up.¹¹⁹ Normalising mental illness in this way may help to explain why, in 2010, 44% of the Australian public believed that people with schizophrenia can self-manage their illness.¹²⁰ A concern associated with normalising campaigns is that they succeed in further marginalising people who experience a severe mental illness that manifests in less socially tolerable behaviours.¹²¹ Instead of combating stigma these styles of campaigns appear to reinforce it.

3.5 Harsher treatment

Mehta and Amerigo’s study¹²² of the effects of the disease model found that the public felt that it must be kind to people whose mental illness is conspicuous but that it actually treats the person more harshly if their illness is described in disease terms.¹²³ This contradiction between what is felt and what is done is not apparent if the illness is described in psychosocial terms. This mirrors the findings in the Rothaus employment interview study 35 years earlier.¹²⁴ The disease view tends to

¹¹⁶ *Ending Stigma and Achieving Parity in Mental Health: A Physician Perspective*, Summary of Presentations and Key Emerging Themes, Toronto, Canada, September 2010,

<<http://www.mooodisorderscanada.ca/documents/Advocacy/Stigma%20Workshop%20Report.pdf>>

¹¹⁷ David Goldberg and Peter Huxley, *Common mental disorders a bio-social model* (Routledge, 1992). This statistic initially was taken from a large scale study published first in 1980, then updated again 1992. Also see United Kingdom Office for National Statistics, ‘Psychiatric Morbidity Report’ (Report, 2000)

<<http://www.ons.gov.uk/ons/rel/psychiatric-morbidity/psychiatric-morbidity-among-adults-living-in-private-households/2000/index.html>>.

¹¹⁸ United States Department Of Health And Human Services, ‘Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings’ (Report, 2010)

<http://www.samhsa.gov/data/NSDUH/2k10MH_Findings/2k10MHResults.htm>. See also Australian Bureau of Statistics, ‘National Survey of Mental Health and Wellbeing: Summary of Results’ (Report, ABS, 2007)

<<http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4326.0Media%20Release12007?opendocument&tabname=Summary&prodno=4326.0&issue=2007&num=&view=>>>.

¹¹⁹ Defined by the Victorian government as ‘mental health problems’ Victorian Government, <http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Mental_health_problems_early_care_helps>.

¹²⁰ Stollznow Pfizer Health Report Wave 2 - *Views and Understanding of Schizophrenia and Bipolar Disorder in Australia*, October 2010,

<http://www.pfizer.com.au/sites/au/news_and_media/media_releases/Pages/StigmaofseverementalillnessescontinuestoriseinAustralia.aspx>

¹²¹ ‘Cosmetic anti-stigma campaigns miss the point’ (2012) 4 *NSSS Advocacy Bulletin*

<<http://www.northshoreschizophrenia.org/images/2012%20Feb%20Advocacy%20Bulletin.pdf>>.

¹²² Mehta and Amerigo, above n 57.

¹²³ Ibid, 415.

¹²⁴ Paul Rothaus, ‘Describing psychiatric hospitalization: A dilemma’ (1963) 18 *The American Psychologist* 85.

engender awareness that there should be generosity of thought directed toward the person but produces the concurrent awareness that the person is 'set apart from the rest of humanity.'¹²⁵ They are perceived to be different from 'us' and this sense of difference, or 'Otherness', is central to the description of mental illness.¹²⁶ Attitudes based on difference create an image of an inferior person standing outside normal standards of human interaction.

Promoting a disease view of mental illness reminds the public of its susceptibility to a chance in which one in five healthy people will become 'mentally ill' at anytime.¹²⁷ Feeling under constant threat can prompt the harsh treatment of those who have already succumbed to mental illness as they are seen as perpetual reminders of the public's vulnerability.¹²⁸ Mehta and Amerigo's study found little support for the position that regarding mental illness as a sickness would 'promote greater acceptance and more favourable treatment'.¹²⁹ In fact, it may cause the adoption of a patronising attitude where the person is not blamed for their socially unacceptable behaviours but is simply thought to require firm, disciplined, thereby harsher, treatment to control the output of unacceptable behaviours. By viewing the person as diseased, they are identified as different which can engender callousness¹³⁰ within thought and lead to harsh actions.¹³¹ These negative attitudes and unfair behaviours are apparent in the parenting decisions that are discussed in Chapter Six.

3.6 Violence

Phelan established that the public of the 1950s had an unscientific understanding of mental illness; was unable to identify individuals as having a mental illness unless their behaviour was extreme, namely psychotic; was unskilled in distinguishing mental illness from ordinary unhappiness and anxiousness; and feared the mentally

¹²⁵ Mehta and Amerigo, above n 57, 416.

¹²⁶ Juliet Foster, 'Unification and differentiation: A study of social representations of mental illness' (2001) 10 *Papers on Social Representations* 1.

¹²⁷ One in five Americans, or 45 million adults, experienced some form of mental illness in 2009. Source: 2009 National Survey on Drug Use and Health: Volume I. Summary of National Findings released in November, 2010, <<http://oas.samhsa.gov/NSDUH/2k9NSDUH/2k9Results.htm>>

¹²⁸ Mehta and Amerigo, above n 57, 416.

¹²⁹ Ibid 417.

¹³⁰ Ibid 416.

¹³¹ Nicholas G Procter, '“They first killed his heart (then) he took his own life”: Reaching out, connecting and responding as key enablers for mental health service provision to multicultural Australia' (2006) 5 *Advances in Mental Health* 81.

ill as dangerous and unpredictable.¹³² By the latter part of the 1990s, the public largely attributed mental illness to a combination of biological abnormalities and vulnerabilities and social and psychological stresses; was able to define mental illness; and could separate mental illness from life's ordinary, albeit, distressing experiences.¹³³ However, only 13% of people surveyed in the 1950s¹³⁴ linked violence to mental illness. The percentage had increased to 31% by 1996.¹³⁵

The 'British Attitudes to Mental Illness 2007' survey found that there had been an increase in prejudice across a wide variety of indicators including the belief that people with mental health problems are 'prone to violence' and that younger people are more likely to hold negative attitudes.¹³⁶ The 2010 follow up survey found that agreement with the statement that 'We need to adopt a more tolerant attitude towards people with mental illness' had fallen from 92% in 1994 to 87%.¹³⁷ Also in 2010, Pescosolido *et al.* published the results of their 10-year comparison of public endorsement of treatment, and prejudice.¹³⁸ They found that the majority of respondents reported that a person with schizophrenia was likely to be violent towards others, and that significantly more respondents in the 2006 survey than the 1996 survey reported an unwillingness to have someone with schizophrenia as a neighbour.

A major finding of the study was that '... holding a neurobiological conception of mental illness either was unrelated to stigma or increased the odds of a stigmatizing reaction.... In no instance was a neurobiological conception associated with significantly lower odds of stigma.'¹³⁹ In his study assessing the efforts to reduce stigmatisation by providing specific information regarding the relationship between mental illness and violence, Penn concluded that some information such as the role

¹³² Phelan *et al.*, above n 16.

¹³³ Mental Health, Report of the Surgeon General, 1999, Chapter 1, <<http://www.surgeongeneral.gov/library/mentalhealth/chapter1/sec1.html>>

¹³⁴ Phelan *et al.*, above n 16.

¹³⁵ Ibid

¹³⁶ Attitudes to Mental Illness 2007 Research Report, June 2007. The report presents the findings of a survey of attitudes towards mental illness among adults in England. The survey was commenced in 1994 and were initially carried out annually, then every three years from 1997-2003, and again annually since 2007. The aim of the surveys is to monitor public attitudes towards mental illness, and to track changes over time <http://webarchive.nationalarchives.gov.uk/20120406161400/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_076516>

¹³⁷ Attitudes to Mental Illness, 2010 Research Report, March 2010 .p.4. <http://webarchive.nationalarchives.gov.uk/20120502171823/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_114795>

¹³⁸ Pescosolido *et al.*, above n 69.

¹³⁹ Ibid, 1324.

that acute symptoms has in initiating violent behaviour can have a deleterious effect on the public's perceptions of dangerousness, and increase the fear of people with schizophrenia.¹⁴⁰ In 2010, an Australian survey of more than two and a half thousand Australians found that 47% of respondents believed that schizophrenia meant 'having violent tendencies' which was a dramatic rise from the reported 32% in 2006.¹⁴¹ The perceived danger associated with people experiencing mental illness has not decreased significantly, although a neurobiological conception was found to increase the likelihood of support for treatment but this was generally unrelated to stigma.¹⁴²

The evidence suggests that while the public demonstrates a greater scientific understanding of mental illness than in the past, this newly found knowledge has not defused social stigma, which remains at high levels¹⁴³, and with some variables such as the apprehension of violence having increased appreciably.¹⁴⁴ Where there was an association, 'the effect was to increase, not decrease, community rejection'.¹⁴⁵ Generally, the perception of mental illness has become more negative, statistically increasing four-fold, due primarily to the association of mental illness with violence.¹⁴⁶ It is unlikely that the politicians, judges, prosecutors, lawyers, child protection and probation and parole officers and clerks that are the mainstay of the legal system are immune from the increases in the public's perceptions of violence associated with mental illness.

The legal system reports large increases in violence with one Victoria Legal Aid branch indicating an overall funding assistance increase of 20% for family violence matters in 2011-12 compared to the previous financial year.¹⁴⁷ 'There is a well-established relationship between the experience of intimate partner violence and

¹⁴⁰ Penn *et al.*, above n 51.

¹⁴¹ Stollznow Pfizer, above n 120.

¹⁴² Pescosolido *et al.*, above n 69, 1321.

¹⁴³ Pescosolido *et al.*, above n 19. See also Bernice A Pescosolido *et al.*, "'A Disease Like Any Other'?" A Decade of Change in Public Reactions to Schizophrenia, Depression, and Alcohol Dependence' (2010) 167 *American Journal of Psychiatry* 1321, 1325. See also George Schomerus, 'Evolution of Public Attitudes about Mental Illness: A Systematic Review and Meta-Analysis' (2012) 125 *Acta Psychiatrica Scandinavica* 440. See also Andrew R Payton and Peggy A Thoits, 'Medicalization, Direct-to-Consumer Advertising, and Mental Illness Stigma' (2011) 1 *Society and Mental Health* 55.

¹⁴⁴ Phelan, above n 16.

¹⁴⁵ Pescosolido *et al.*, above n 69, 1321.

¹⁴⁶ *Ibid* 1325.

¹⁴⁷ Clark Quirk, 'Family violence court cases rise 20 per cent', *The Standard* (online), 12 November 2012 <<http://www.standard.net.au/story/967113/family-violence-court-cases-rise-20-per-cent/>>.

mental health problems’.¹⁴⁸ There is also evidence that the fear/risk of violence associated with parents with a mental illness is a key factor in the parenting order decisions (see Chapter Six) and in regard to preventative detention (discussed below), but there needs to be much more research undertaken regarding the extent to which the legal system disadvantages parties with a mental illness because the association mental illness has with violence.

3.7 Preventative action

Although much of the literature focuses on the criminal law aspects of preventative detention, such as serious sexual offender’s legislation¹⁴⁹, preventative action has long been a medically, legally and publically acceptable process for interacting with people experiencing a mental illness. According to Szasz, ‘mental illness’ is a term that implies dangerousness, which in turn justifies psychiatric coercion.¹⁵⁰ Research shows that society is much more inclined to endorse legal coercion such as forced medication and, if necessary, involuntary admission to psychiatric hospitals than it was more than a decade ago.^{151 152}

Genetic and chemical imbalance arguments are positively associated with recommending medical treatment, but not with the perceived likelihood of improvement. Genetic arguments make a person appear more threatening than they were when they were thought to be more responsible for their behaviour.¹⁵³ The only other causative belief that appears to have a significant positive association with support of coerced treatment is ‘bad character’ which, particularly in regard to schizophrenia, is indistinguishable from genetics. ‘In their effects, if hardly their content, “bad genes” resemble “bad character”’.¹⁵⁴

¹⁴⁸ Leah Bromfield, Alister Lamont, Robyn Parker and Briony Horsfall, ‘Issues for the safety and wellbeing of children in families with multiple and complex problems: The co-occurrence of domestic violence, parental substance misuse, and mental health problems’ (National Child Protection Clearinghouse, Issue 33, 2010) 5.

¹⁴⁹ Corey Rayburn Yung, ‘Symposium: Preventative Detention: Sex Offender Exceptionalism and Preventive Detention’ (2011) 101 *Journal of Criminal Law and Criminology* 969. See also Patrick Keyzer, ‘The United Nations Human Rights Committee’s views about the legitimate parameters of the preventive detention of serious sex offenders’ (2010) 34 *Criminal Law Journal* 283. See also Bernadette McSherry and Patrick Keyzer, *Sex Offenders and Preventive Detention: Politics, Policy and Practice* (Federation Press, 2009)

¹⁵⁰ Thomas Szasz, ‘Psychiatry and the control of dangerousness: on the apotropaic function of the term “mental illness”’ (2003) 29 *Journal of Medical Ethics* 227.

¹⁵¹ Schnittker, above n 65.

¹⁵² Pescosolido *et al.*, above n 69.

¹⁵³ Schnittker, above n 65.

¹⁵⁴ *Ibid* 1376.

Stigma exaggerates violence, both justifying and affirming the social need for a coercive response to mental illness. The law then demands that the psychiatrist makes a prediction in response to the ill-conceived, stereotypically obvious question ‘Is this person dangerous?’, as if dangerousness is an inherent, chronic, life-long and unchanging quality instead of an ascribed, unobjective quality that cannot be identified or measured.¹⁵⁵ Dangerousness is not a diagnosis but a legal status although determining its presence requires a normative judgment.¹⁵⁶ Even though the law expects and accepts the psychiatrist’s opinion as legal evidence, it acknowledges that ‘psychiatrists notoriously overpredict’¹⁵⁷ and that risk of harm predictions are not very accurate.^{158 159} The consequence of these inaccuracies is that large numbers of people who would not go on to cause, or experience harm, are classified as representing a high risk of harm.¹⁶⁰ Individuals are unfairly, and incorrectly, institutionally labelled. The exaggerated classification also fuels the public’s fears that people experiencing a mental illness are dangerous, and reinforces the belief that the law must implement harsh preventative actions to restrict and detain.

Greely has raised the issue of the intertwined complexities of accuracy, fairness and prediction. If, he asks, there was an accurate neuroscience test which could predict that a person would be a paedophile; would it be fair, or ethical, to take preventative action such as detaining them; informing their neighbours, or warning potential employers, before they had actually committed any wrong?¹⁶¹ Fairness and ethics have little resonance when a prediction of harm or dangerousness often results in a person being involuntarily detained and/or forcibly treated under mental health legislation, and/or subjected to guardianship and administrative regulations restricting their autonomous freedoms in personal matters of finance, treatment and lifestyle choices.

¹⁵⁵ Morris Vinestock, ‘Risk assessment: A word to the wise?’ (1996) 2 *Advances in Psychiatric Treatment* 3.

¹⁵⁶ Robert I Simon, ‘The Myth of “Imminent” Violence In Psychiatry and the Law’ (2006) 75 *University Of Cincinnati Law Review* 631.

¹⁵⁷ Kate Warner, ‘Sentencing Review 2002-2003’ (2003) 27 *Criminal Law Journal* 325, 338. See also *Fardon v Attorney-General (Qld)* (2004) 223 CLR 575, 124 (Kirby J).

¹⁵⁸ Charles W Lidz, Edward P Mulvey and William Gardner, ‘The accuracy of predictions of violence to others’ (1993) 269 *Journal of American Medical Association* 1007.

¹⁵⁹ *Fardon v Attorney-General (Qld)* (2004) 223 CLR 575, 125 (Kirby J).

¹⁶⁰ Matthew M Large *et al.*, ‘The Predictive Value of Risk Categorization in Schizophrenia’ (2011) 19 *Harvard Review of Psychiatry* 25.

¹⁶¹ Henry T Greely, ‘The Social Consequences of Advances in Neuroscience: Legal Problems, Legal Perspectives’ in Judy Illes (ed), *Neuroethics: Defining the Issues in Theory, Practice and Policy* (Oxford University Press, 2005).

3.8 Neuroimaging and the law

Mental states are fundamental to law and ‘blame shift’ is most apparent in matters of criminal responsibility and mitigation/sentencing. Criminal law presupposes the ‘folk psychological’¹⁶² view of the person and their behaviour, focusing largely on the portion that guides the prediction and explanation of actions.¹⁶³ If a person lacks the relevant mental capacity at the time of an offence, then a legal excuse such as insanity is warranted. Recently, courts have been increasingly confronted by scientific findings in behavioural genetics, neuroscience, and other rapidly advancing disciplines. This has raised concerns regarding the judges need for guidance from the medical profession to decide the proper use of the neuroimage, and the need to assess the qualifications and calibre of the expert testimony that accompanies the image into court.¹⁶⁴ With behavioural genetics likely to be the next frontier in criminal justice, making sense of the new data will require courts to place even greater reliance on the mental health professional.¹⁶⁵

The past several decades have seen a large amount of literature produced on the intersection of neuroimaging and law by commentators from the fields of medicine, law and the social sciences,¹⁶⁶ many of whom believe that the introduction of neuroimaging into the court process to establish proof in all matters regarding a party’s mental state or capabilities is inevitable.¹⁶⁷ Structural neuroimages presently provide an often compelling visual blueprint of the workings of the brain within the courtroom but its critics claim that the evidence is more seductive than scientific because the image and its interpretation are subject to manipulation and distortion.¹⁶⁸ Many commentators have also raised concerns surrounding the risk of misuse of brain imaging in the courtroom, questioning whether the adversarial

¹⁶² Folk psychology is the term given to the information that lay people have about the mind.

¹⁶³ Lynn Nadel (ed), *Encyclopedia of Cognitive Science* (Nature Publishing, 2002) Shaun Nichols, ‘Folk Psychology’.

¹⁶⁴ Laura Stephens Khoshbin and Shahram Khoshbin, ‘Imaging the Mind, Minding the Image: An Historical Introduction to Brain Imaging and the Law’ (2007) 33 *American Journal of Law and Medicine* 171, 191.

¹⁶⁵ Paul S Appelbaum, ‘Law & Psychiatry: Behavioral Genetics and the Punishment of Crime’ (2005) 56 *Psychiatric Services* 25.

¹⁶⁶ John H Blume and Emily C Paavola, ‘Life, Death, and Neuroimaging: The Advantages and Disadvantages of the Defense’s Use of Neuroimages in Capital Cases – Lessons from the Front’ (Research Paper Series No 11-18, Cornell Law School, 23 May 2011) 1 <http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1856188>.

¹⁶⁷ Neal Feigenson, ‘Brain imaging and courtroom evidence: on the admissibility and persuasiveness of fMRI’ (2006) 2 *International Journal of Law in Context* 233, 233.

¹⁶⁸ Donald Reeves *et al.*, ‘Limitations of Brain Imaging in Forensic Psychiatry’ (2003) 31 *Journal of American Academy of Psychiatry and Law* 89.

system is an improper forum for determining the evidentiary validity of neuroimaging evidence.¹⁶⁹

Neuroimaging is seen as particularly vulnerable to misuse and misunderstanding in what it is that the image is actually showing, and what it actually means.¹⁷⁰ It does not have an automatic, self-evident significance and no matter how well designed, executed and analysed, it still requires its import, in context, to be interpreted.¹⁷¹ There is no standard followed in the production and presentation of this type of evidence, which can easily be manipulated by someone with knowledge of technology.¹⁷² Perlin suggests that while jurors might respond positively to the science of neuroimaging evidence in insanity defence cases, they could also respond negatively according to their prejudices: fear and loathing of insanity pleaders.¹⁷³ What is certain is that this type of scientific evidence is likely to be increasingly used to guide future courts in decisions about, for example, culpability, sentencing and preventative detention.

3.8.1 Structural Neuroimaging Evidence

The United States has a surprisingly high admissibility rate for structural type neuroimaging evidence such as the Computerised Tomography (CT) scans and diagnostic Magnetic Resonance Imaging (MRI) scans which use magnetic fields and radio waves to take detailed ‘pictures’ of the brain.¹⁷⁴ This may be a consequence of the large proportion of bench proceedings in which a judge typically hears the evidence and then makes a determination as to the weight to be applied to it. It is less likely to be admitted into testimony in hearings in which a jury has been empanelled because the evidence is likely to be deemed not sufficiently reliable.¹⁷⁵ American courts have been more circumspect about admitting into evidence functional neuroimaging such Positron Emission

¹⁶⁹ Khoshbin and Khoshbin, above n 164, 191.

¹⁷⁰ Ibid.

¹⁷¹ Owen D Jones *et al.*, ‘Brain Imaging for Legal Thinkers: A Guide for the Perplexed’ (2003) 5 *Stanford Technology Law Review* <<http://stlr.stanford.edu.ezproxy.utas.edu.au/pdf/jones-brain-imaging.pdf>>.

¹⁷² Donald Reeves *et al.*, ‘Limitations of Brain Imaging in Forensic Psychiatry’ (2003) 31 *Journal of American Academy of Psychiatry and Law* 89.

¹⁷³ Michael L Perlin, ‘“Good and Bad, I Defined These Terms, Quite Clear No Doubt Somehow”: Neuroimaging and Competency to be Executed after Panetti’ (2010) 28 *Behavioral Sciences and the Law* 671, 674–5.

¹⁷⁴ Martha Shenton, Thomas J Whitford and Marek Kubicki, ‘Structural neuroimaging in schizophrenia from methods to insights to treatments’ (2010) 12 *Dialogues in clinical neuroscience* 317.

¹⁷⁵ Feigenson, above n 167, 237.

Tomography (PET) scans and Single Photon Emission Computed Tomography (SPECT) scans to prove either insanity or incompetency, but have been relatively lenient regarding their admissibility in death penalty hearings.¹⁷⁶

Structural neuroimages are also ‘routinely admitted into evidence in civil and criminal trials in Australia’.¹⁷⁷ Courts have accepted them as a scientific tool for determining the presence of a brain injury due to trauma¹⁷⁸, diagnosing a brain injury¹⁷⁹, ruling in or out the cause of the brain injury¹⁸⁰, declaring brain death¹⁸¹, assessing whether a brain is juvenile or adult¹⁸², establishing testamentary capacity and dementia¹⁸³ and establishing a mental illness.¹⁸⁴ However, it will be rare, if indeed even possible, to establish a direct and unequivocal chain of causation between the identified abnormal condition of the brain of a person and the person’s unacceptable, inappropriate and deviant behaviour.¹⁸⁵ In criminal cases, this raises the concern that neuroimaging evidence may lead jurors to believe that the structural brain abnormality was the proximate cause for the functional bad conduct.

¹⁸⁶

3.8.2 Functional Neuroimaging Evidence

Despite the high profile that academic attention, media and public interest has given to functional neuroimaging, they have rarely been used internationally, and to date, have not been successfully introduced into evidence in either a criminal or civil trial in Australia.¹⁸⁷ Functional neuroimaging measures aspects of brain function usually with the view of understanding the relationship between activity in certain areas of

¹⁷⁶ Jane Campbell Moriarty, ‘Flickering Admissibility: Neuroimaging Evidence in the U.S. Courts’ (2008) 26 *Behavioral Sciences and the Law* 29.

¹⁷⁷ Leanne Houston and Amy Vierboom, ‘Neuroscience and Law: Australia’ in Tade Mathias Spranger (ed), *International Neurolaw: A Comparative Analysis* (Springer, 2012) 11.

¹⁷⁸ *R v Jeong Ming Foo* [2008] NSWSC 587.

¹⁷⁹ *Tabet v Gett* [2010] HCA 12.

¹⁸⁰ Feigenson, above n 167.

¹⁸¹ *R v KT* [2007] NSWSC 83. See also Loane Skene, ‘Neuroimaging and the Withdrawal of Life-Sustaining Treatment from Patients in Vegetative State’ (2009) 17 *Medical Law Review* 245.

¹⁸² *Roper v. Simmons*, 543 U.S. 551 (2005) (No.03–633). The U.S. Supreme Court in *Roper* banned the death penalty for offenders under the age of 18 years due to brain imagery evidence that indicated that the regions of the brain responsible for decision making and impulse control are not as well developed in adolescents as in adults, and therefore adolescents are less culpable for the crimes they commit.

¹⁸³ *Burgess v Leech* [2007] NSWSC 700.

¹⁸⁴ *R v Coleman* [2010] 9NSWSC 177.

¹⁸⁵ Kirsten Nugent, ‘Neuroimaging in Criminal Trials: Evidentiary and Constitutional Concerns’ (Research Paper, SeletedWorks, January 2009) <http://works.bepress.com/kristen_nugent/4>.

¹⁸⁶ *Ibid.*

¹⁸⁷ Leanne Houston and Amy Vierboom, ‘Neuroscience and Law: Australia’ in Tade Mathias Spranger (ed), *International Neurolaw: A Comparative Analysis* (Springer, 2012).

the brain and specific mental functions.¹⁸⁸ Their value in the legal context has largely been speculative, with suggested uses being the detection of deception or the compelling of truth;¹⁸⁹ determining racial or other bias on the part of jurors or witnesses, determining mental capacity for the purposes of criminal responsibility and fitness to plead;¹⁹⁰ deciding civil competency in the execution of contracts and wills, and the giving of informed consent; proving the presence of intractable pain, proving addiction or susceptibility to addiction; showing a disposition to sexual deviance or predatory impulses; and predicting future dangerousness.¹⁹¹

The law-influenced discussions surrounding the possible uses of functional neuroimaging have raised far more questions than provided any real answers, although the questions themselves are viewed as beneficial in maximising the benefits and minimising the harms associated with the new neuroscience technologies.¹⁹² How much accuracy, and of what kind, would there need to be to the prediction before the law intervened? Whether a structural neuroimage supports a psychiatric diagnosis such as schizophrenia or not is an entirely different question to whether for example, the defendant knew the nature or wrongfulness of their behaviour at the time of the crime.¹⁹³ Establishing the presence of a brain abnormality by a structural neuroimage may raise a reasonable doubt in the juror's mind as to the defendant's ability to form the necessary *mens rea*.¹⁹⁴ However, the psychiatrist would need to assess criminal intent from a functional neuroimage by identifying not only what a thought looks like, but also recognising what in particular, a bad or antisocial thought looked like long after the criminal intent had passed.¹⁹⁵ Neuroimaging has the potential to advantage people experiencing mental illness but it also has the potential to disadvantage them.¹⁹⁶

¹⁸⁸ Tor D Wager, Luis Hernandez, and Martin A Lindquist, 'Essentials of functional neuroimaging', *Handbook of Neuroscience for the Behavioral Sciences*, 2009, <http://tauruspet.med.yale.edu/staff/edm42/courses/ENAS_880_2012/papers/chapters/Wager_fMRICHap_2008_text_tables_r1.pdf>

¹⁸⁹ Feigenson, above n 167.

¹⁹⁰ Joseph R Simpson (ed), *Neuroimaging in Forensic Psychiatry: From Clinic to the Courtroom* (Wiley-Blackwell, 2012).

¹⁹¹ Greely, above n 161.

¹⁹² *Ibid*.

¹⁹³ Donald Reeves *et al.*, 'Limitations of Brain Imaging in Forensic Psychiatry' (2003) 31 *Journal of American Academy of Psychiatry and Law* 89.

¹⁹⁴ Joseph R Simpson (ed), *Neuroimaging in Forensic Psychiatry: From Clinic to the Courtroom* (Wiley-Blackwell, 2012).

¹⁹⁵ *Ibid*.

¹⁹⁶ Sinnott-Armstrong *et al.*, above n 91. See also John H Blume and Emily C Paavola, 'Life, Death, and Neuroimaging: The Advantages and Disadvantages of the Defense's Use of Neuroimages in Capital Cases –

4. POLITICAL CORRECTNESS AND THE REGULATION OF LANGUAGE

The 1950s commenced a watershed of social changes in which issues of diversity, inclusion, social equity and multiculturalism found expression in policy interventions and laws that were intended to govern human behaviour, solve social problems, and make the lives of disadvantaged people better. A range of tools including legislation, regulations and legal sanctions and the provision of public services, and information and guidance materials were used to influence community behaviour and confer economic, social and community benefits.¹⁹⁷ Marginalised populations possessing immutable qualities of gender, race, ethnicity, sexuality and youth began accumulating a swag of newly recognised rights and protections via this mix of social justice/human rights policies and materials, affirmative action/anti-discrimination legislation such as the *Disability Discrimination Act* 1992 (Cth) and *Racial Discrimination Act* 1995 (Cth);¹⁹⁸ and social change decisions handed down by liberal courts with landmark rulings such as *Hickie v Hunt and Hunt*¹⁹⁹, *Maguire v SOCOG*²⁰⁰, *McBain v Victoria*²⁰¹ and *Mabo (1)*.^{202 203}

One of the most important tools in the armoury of the social justice advocates wanting to overcome the disadvantages and barriers experienced by various oppressed or marginalised social groups is political correctness: the careful use of language so as not to disrespect, or exclude disadvantaged groups from full political and civic participation.²⁰⁴ Once social/legal change has acquired a particular degree of significance, the socio-cultural process of political correctness attempts to

Lessons from the Front' (Research Paper Series No 11-18, Cornell Law School, 23 May 2011) 1 <http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1856188>.

¹⁹⁷ Australian Public Service Commission, 'Changing Behaviour: A Public Policy Perspective' (Research Paper, Australian Public Service Commission, 2007) <http://www.apsc.gov.au/__data/assets/pdf_file/0017/6821/changingbehaviour.pdf>.

¹⁹⁸ Some examples of Australian legislation are the *Age Discrimination Act* 2004 (Cth); *Australian Human Rights Commission Act* 1986 (Cth); *Disability Discrimination Act* 1992 (Cth); *Racial Discrimination Act* 1975 (Cth); *Sex Discrimination Act* 1984 (Cth).

¹⁹⁹ *Hickie v Hunt and Hunt* [1998] HREOCA 8.

²⁰⁰ *Bruce Lindsay Maguire v. Sydney Organising Committee for the Olympic Games* (Respondent) H 99/115 (2000).

²⁰¹ *McBain v Victoria* (2000) 99 FCR 116.

²⁰² *Mabo v Queensland* (No. 1) (1988) 166 CLR 186; *Mabo v Queensland* (No 2) ('Mabo case') [1992] HCA 23.

²⁰³ Similar international landmark decisions included *Brown v. Board of Education of Topeka*, 347 U.S. 483 (1954) *Roe v. Wade*, 410 U.S. 113 (1973), *Lawrence v Texas*, 539 U.S. 558 (2003), *R v R* [1992] 1 A.C. 599, House of Lords, *Loving v. Virginia*, 388 U.S. 1 (1967), *O'Connor v. Donaldson*, 422 U.S. 563 (1975), *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402 (HL).

²⁰⁴ Robert Sparrow, 'Talking sense about political correctness' (2002) 26 *Journal of Australian Studies* 119.

stabilise the new order²⁰⁵ although its critics argue that this presents the danger of government censoring of free speech.²⁰⁶ However, manipulating or censoring language use is unlikely to cure the deeply held prejudices and entrenched social disadvantages that drive offensive language.

This section explores how political correctness when associated with a social issue such as racism is connected to laws that are then used to regulate and sanction language that is deemed racially offensive. It shows through the lens of immigration policy and law how the language of ‘political correctness’ is manipulated to support different political agendas, and justify legal decision-making. Racism and immigration law are discussed because no similar processes have occurred regarding the use of offensive and disrespectful language associated with mental illness. Racist language is considered legally offensive language while sanist language is socially, and therefore, legally acceptable language. The section leads into Perlin’s argument in Chapter Five that sanism is a socially acceptable phenomenon.

4.1 A politically correct society

A civilised society is a ‘politically correct’ society.²⁰⁷ Political correctness is an ideology that seeks to alter the rules, formal and informal, that govern relations amongst people and institutions and in Australia; its primary meaning is as a reference to the criticism and regulation of speech.²⁰⁸ It arises out of idealistic motives and moral values, and is an attempt to change the way that a group is perceived by taking control of language, and steering its use in a particular direction.²⁰⁹ Concepts and terminology are the cognitive apparatus used to establish groups, and group identities, and ‘political correctness’ is the tool used to change negative behaviour, thought and language about the group thereby eliminating prejudice and discrimination.²¹⁰

²⁰⁵ Peter Klotz, ‘Politeness and Political Correctness: Ideological Implications’ (1999) 9 *Pragmatics* 155.

²⁰⁶ Sparrow, above n 204.

²⁰⁷ Polly Toynbee, ‘This bold equality push is just what we needed. In 1997’, *The Guardian* (online) 28 April 2009 <<http://www.guardian.co.uk/commentisfree/2009/apr/28/toynbee-equality-bill-welfare>>.

²⁰⁸ Sparrow, above n 204.

²⁰⁹ Klotz, above n 205.

²¹⁰ William S Lind, “‘Political Correctness:’ A Short History of an Ideology” (Research Paper, Free Congress Foundation, November 2004) <<http://www.scribd.com/doc/2674655/Political-Correctness-A-Short-History>>.

Its most recognisable feature is the regulation of speech by banning the use of ‘offensive’ words and verbal expressions and replacing them with euphemisms and circumlocutions.²¹¹ Its proposition is that language not only represents thought but can also be used to control thought.²¹² This assumes that if linguistic behaviour is changed, social inequality will be reduced²¹³ and a more inclusive society will be created because it will be equipped with a homogeneous and consensual set of moral norms and behavioural standards. This assumption of a more equitable society is foundational to the use of less pejorative, more ‘politically correct’ language intended to counteract negative descriptors, and ultimately, negative attitudes.

Leading up to the enactment of the United Kingdom’s *Equality Act* 2010, the populist view expressed at the time was that ‘[t]he phrase “political correctness” was born as a coded cover for all who still want to say Paki, spastic or queer, all those who still want to pick on anyone not like them, playground bullies who never grew up’.²¹⁴ Yet in the present, more equal Britain, Lord Rodger in his judgment in *HJ (Iran) (FC) v Secretary of State for the Home Department*²¹⁵ still felt comfortable resorting to trivial stereotypes when he found that foreign homosexuals claiming asylum were entitled to the same freedoms as British gays, which was ‘to enjoy themselves going to Kylie concerts, drinking exotically coloured cocktails and talking about boys with their straight female mates’.²¹⁶ Perhaps presumptively, the use of politically correct language is claimed as a key factor in the success of campaigns opposing discrimination based on gender, age, religion, race and physical disability.²¹⁷

²¹¹ Hans Geser, ‘Political Correctness: mental disorder, childish fad or advance of human civilization? In: *Sociology in Switzerland*, Online Publication, Zurich, Jan. 2008,

<http://www.forschungsnetzwerk.at/downloadpub/Political_Correctness_pc_geser2008.pdf>

²¹² For many critics, enforcing political correctness is equivalent to ‘thought policing’. See Suzan Poyraz, ‘The Charge of Thought-Policing in Universities’ (2006) 36 *The Canadian Journal of Higher Education* 65. See also Joan Wallach Scott, ‘The Campaign Against Political Correctness: What’s Really at Stake’ (1992) 54 *Radical History Review* 59.

²¹³ Edna Andrews, ‘Cultural Sensitivity and Political Correctness: The Linguistic Problem of Naming’ (1996) 71 *American Speech* 389.

²¹⁴ Toynbee, above n 207.

²¹⁵ [2010] UKSC 31

²¹⁶ *HJ (Iran) (FC) v Secretary of State for the Home Department* [2010] UKSC 31 at para 78. On appeal from: [2009] EWCA Civ 172

²¹⁷ Byrne, above n 66, 67. See also IRS Reddy, ‘Making psychiatry a household word’ (2007) 49 *Indian Journal of Psychiatry* 10.

4.2 Tyranny of manners

‘Political correctness’ or what pundits refer to as ‘a tyranny of manners’²¹⁸, is a concept that has become as disagreeable to its critics as the prejudices perpetrated against people who have a mental illness are to mental health advocates. The exponents of political correctness are increasingly viewed as self-righteous; a sort of vanguard of enlightenment that does not accept the judgment of dissenters, and is prepared to impose reforms against the public will.²¹⁹ Social and political causes ranging from medical practitioner resistance to the establishment of a pregnancy and drugs database on the ground of privacy²²⁰ to the implementation of civil partnership legislation²²¹ are touted by their opponents as ‘political-correctness-gone-mad’: unpredictable, uncontrolled and dangerous.

Its opponents argue that the imposition of ‘a new orthodoxy is not the way to tackle prejudice’²²², claiming that it is itself the most pernicious form of intolerance because it comes disguised as tolerance.²²³ Whereas the intent of political correctness was to change behaviour, thought and language, and eliminate prejudice and discrimination, behaviour, thought and language appear to have combined to further stigmatise mental illness through their forced association with an increasingly unpopular ideology. Professor Hans Geser’s sanist criticism reinforces the unhealthy association of political correctness and mental illness:

[p]olitical correctness is certainly a very ianus-faced²²⁴ thing: an advance in human civilisation as well as a childish fad - and that some considerable efforts of self-clarification and self-criticism may be necessary to make sure

²¹⁸ Charlton Heston, “If Americans believed in political correctness, we’d still be King George’s boys -- subjects bound to the British crown.” An excerpt from a speech by Charlton Heston entitled ‘Winning the Cultural War’, delivered at Harvard Law School, 16 February 1999. Heston called those law students who validated, and abided by political correctness, cowards. He would later coin the popular phrase, “Political correctness is simply tyranny with manners”. Richard Corliss, ‘Appreciation: Charlton Heston’, *Time* (online), 6 April 2008 <<http://www.time.com/time/arts/article/0,8599,1728272-3,00.html>>.

²¹⁹ Peter Coleman, ‘What is Political Correctness? The Pros and Cons’, *Quadrant* (online), 1 March 2000 <<http://www.liberalsindia.com/relevance/PoliticalCorrectness.php>>.

²²⁰ E J Begg, ‘Prescribing in pregnancy and lactation’ (2008) 65 *British Journal of Clinical Pharmacology* 627.

²²¹ Elizabeth Peel, ‘Editorial Introduction: Recognizing and Celebrating Same-Sex Relationships: Beyond the Normative Debate’ (2008) 11 *Sexualities* 659.

²²² Jeff Johnson, ‘Literature, Political Correctness and Cultural Equity’ (1992) 8 *English Today: The International Review of the English Language* 44, 45.

²²³ Ibid.

²²⁴ Ianus or Janus, the Roman god having two faces--one looking to the future and one to the past; having or concerned with polarities or contrasts; marked by deliberate deceptiveness especially by pretending one set of feelings and acting under the influence of another; hypocritical.

that it does not become an almost incurable (because almost unnoticed) kind of collective mental disorder.²²⁵

‘Political correctness’ may be a solution for some but for others it is representative of a problem considered to be just as unpredictable, uncontrolled, dangerous and insidious as the negative labels applied to ‘mentally ill’ individuals: a concept gone mad. While stigma may be viewed as topical and trendy, it is definitely more than a passing fashion.²²⁶ The real question is whether ‘political correctness’, having taken on its own set of stigmatising properties and pejorative connotations, has run its course or whether its influence on the law has ensured its longevity.

5. POLITICAL CORRECTNESS AND THE LAW

There is no unfairness in the court following rules. But there is an unfairness in courts following trends.

Former Canadian Supreme Court Justice, Michel Bastarache²²⁷

Judges do not make letter of the law decisions according to recently retired Canadian Supreme Court Justice Bastarache. Instead, they follow popular global trends in arriving at decisions which are seen to be right and fair. Bastarache claims that judges do not wish to be seen as out of step with ‘progress’ although he suggests that ‘progress can also be seen as political correctness’.²²⁸ Society embraces its commitment to the equity that underlies political correctness and sets great value in the shifts in norms achieved by its commitment.²²⁹ A growing concern for communities that are regulated by political correctness is that its populations ‘feel judged and fear being blamed’.²³⁰ As Bastarache implies, judges worrying about how they are viewed as representatives of their social group can

²²⁵ Geser, above n 211, 38.

²²⁶ Peter Byrne, ‘Psychiatric stigma’ (2001) 178 *The British Journal of Psychiatry* 281.

²²⁷ Jason Hewlett, ‘Legal system needs to stick to law, retired Supreme Court judge says’, *The Daily News* (online), 18 January 2013 <<http://www.kamloopsnews.ca/article/20130118/KAMLOOPS0101/130119821/-1/kamloops/legal-system-needs-to-stick-to-law-retired-supreme-court-judge-says>>.

²²⁸ Hewlett, above n 227.

²²⁹ Robin J Ely, Martin N Davidson and Debra Meyerson, ‘Rethinking Political Correctness’ (2006) 84 *Harvard Business Review* 78.

²³⁰ Ibid 80.

arrive at decisions that are based on untested, private conclusions that may become immutable.²³¹

This section discusses political correctness and the role it has in the law in the areas of racism and immigration. It will show that political correctness as a regulator of speech and behaviour suffers from the same conceptual and definitional weaknesses as terms such as ‘mental illness’ and ‘stigma’ that were discussed in previous chapters. But as a tool, political correctness has become ensconced in legal discussion and statutory interpretation in areas of social concern except in the area of mental health in which offensive, derogatory and disrespectful language is sanctioned by the law on the basis of its social acceptability (See Section 6.0, below).

5.1 Racism and political correctness

Few labels are as aversive in a society where motivations to avoid appearing prejudiced are as increasingly pervasive as that of appearing ‘racist’.²³² And there are few more offensive racist terms than ‘nigger’. The need to be perceived as ‘politically correct’ is considerable, however, the confusion surrounding what phraseology is, and is not ‘politically correct’ is evident.²³³ An example of this is found in the Australian case of *Hagan v Trustees of the Toowoomba Sports Ground Trust*²³⁴ in which the applicant complained that the sign, ‘The ES ‘Nigger’ Brown Stand’ positioned above the local football oval grandstand was a contravention of the provisions of the *Discrimination Act*²³⁵ because the word ‘nigger’ was racially offensive.

Arriving at its decision to dismiss the application, the court turned to the dictionary for the meaning of Negro which informed that, ‘[e]xcept in Black English vernacular, where it remains common, it is now virtually restricted to contexts of deliberate and contemptuous ethnic abuse’.²³⁶ While the term ‘black’ has undergone semantic amelioration and once acceptable racial designations such as ‘coloured’

²³¹ Hewlett, above n 227

²³² Michael I Norton *et al.*, ‘Color Blindness and Interracial Interaction: Playing the Political Correctness Game’ (2006) 17 *Psychological Science* 949.

²³³ Jennifer Grafton and Joanne M Lye, ‘Political correctness, surface tension & passive racism’ (2000) 19 *Youth Studies Australia* 44.

²³⁴ [2000] FCA 1615 (10 November 2000)

²³⁵ *Racial Discrimination Act* 1975 (Cth) ss 9, 18C.

²³⁶ *Hagan v Trustees of the Toowoomba Sports Ground Trust* [2000] FCA 1615 (10 November 2000).

and 'Negro' have undergone semantic pejoration and fallen into desuetude among some groups,²³⁷ it is inaccurate to claim that their use is restricted to contemptuous abuse. Although the term 'Negro' may be considered obsolete by many²³⁸, it was included on the 2010 United States census form. Question 9 asked respondents to indicate whether their race was 'Black, African Am., or Negro'.²³⁹ The Census Bureau claimed that the term offered older African Americans²⁴⁰ a new identifier and that the term was in fact, one of inclusion²⁴¹ as '[m]any older African-Americans identified themselves that way, and many still do...Those who identify themselves as Negroes need to be included.'²⁴² For Americans, the status of 'Negro' is age related with more than half of both the black and white older populations believing that 'Negro' is a respectful term.²⁴³

A 1980s study measuring the preferences that black Americans had for the race names, 'Black', 'Negro' and 'Afro-American'²⁴⁴ found that it related to the individual's underlying sense of identity and consciousness although 'currently, "Black" is in'.²⁴⁵ The researchers concluded that 'black Americans remain somewhat *schizophrenic* (italics added) when it comes to using own- race descriptors and labels'.²⁴⁶ Setting aside the fact that the inaccurate misuse of the term 'schizophrenic' to describe the normal variations in the preference of race descriptors by the members of a particular racial group is demonstratively sanist,

²³⁷ Anita Henderson, 'What's in a Slur?' (2003) 78 *American Speech* 52, 55.

²³⁸ Jack Martin, 'Census Bureau defends 'negro' addition', *The New York Daily News* (online), 6 January 2010 <http://www.upi.com/Top_News/US/2010/01/06/Census-Bureau-defends-negro-addition/UPI-70241262798663/>.

²³⁹ United States Census, 2010, U.S. Department Of Commerce, Economics and Statistics Administration, U.S. Census Bureau <<http://www.census.gov/2010census/>>

²⁴⁰ Census respondents indicated whether they were white, black, or mulatto until 1950 when black and mulatto were replaced with the more 'politically correct' term 'Negro'. Black reappeared in 1970 with a capital B, and Negro remained. African American first appeared in 2000 as one of three choices. NAACP Legal Defense Fund Political Participation Practice Group, <<http://www.thedefendersonline.com/2010/01/11/the-word-negro-and-the-2010-census-form/>>

²⁴¹ Census officials stated that the term was added to the form after some respondents, primarily older blacks, wrote 'negro' on the form in 2000. "Negro" on Census Form Called Offensive, CBS News, 7/1/2010, <<http://www.cbsnews.com/stories/2010/01/07/national/main6067168.shtml>>

²⁴² Martin, above n 238.

²⁴³ Henderson, above n 237, 56.

²⁴⁴ 'In 1988 Jesse Jackson encouraged people to adopt this term over the then-used "black." As he saw it, the words acknowledged black America's ties to Africa. "African American," says Hill, is now "used more by non-African-American people, who cling to it because they are unsure what word to use." Sen says, "African American" is favored by "highly educated people who are not black. Whether one uses 'black' or 'African American' indicates how strong your social relations are with those communities." And Chris Raab, founder of Afro-Netizen, says, "People who are politically correct chose to use African American, but I don't recall any mass of black folks demanding the use of African American.' Excerpt from Joel Bleifuss, 'A Politically Correct Lexicon', *In These Times* (online), 21 February 2007 <http://www.inthesetimes.com/article/3027/a_politically_correct_lexicon/>.

²⁴⁵ Halford H Fairchild, 'Black, Negro, or Afro-American?: The Differences Are Crucial!' (1985) 16 *Journal of Black Studies* 47.

²⁴⁶ Ibid 53.

the researchers suggest that ‘politically correct’ language is language favoured by the powerful at any given time.²⁴⁷ This raises the question as to whether it is the words themselves that are detrimental, or whether the detriment is found in the attitudes behind the speaking and hearing of the words.

The court in *Hagan* found that even if Mr Brown's nickname had had its genesis in bigotry, it had long ago lost its racial connotation. It was helped to this view by the evidence of well known Indigenous community representatives who expressed their acceptance of the public expression of the word ‘Nigger’ used in the context of honouring Mr Brown, a white Australian. The court seemed to believe that a legally offensive word may lose its offensiveness if it can be shown that the term had its inception in the bigotry of the past, has been absorbed into cultural acceptance and practice, and is not presently used with an offensive intent. The court’s view in *Hagan* reflects the concept of a socially acceptable offensiveness, a topic discussed in regard to mental illness in Section 6.0.

5.1.1 Politically correct speech is not free speech

In the Salford Youth Court in the United Kingdom in 2012, a 10 year old boy was prosecuted for racist school name-calling. The case prompted the judge to ask ‘[h]ave we really got to the stage where we are prosecuting 10-year-old boys because of political correctness?’ and ‘Nobody is more against racist abuse than me but these are boys in a playground, this is nonsense.’²⁴⁸ Adjourning the matter, he asked prosecutors to reconsider whether the case was in the public interest stating that in his day, the boys would have gotten a ‘good clouting’.

It appears that this judge may adhere to the popular culture myth that children are colour blind and don’t develop racial prejudices until, and unless, they are explicitly taught although current psychological research shows that children develop racial biases that do not necessarily reflect the racial attitudes of the adults in their lives by the age of three to five.²⁴⁹

²⁴⁷ Historically, black was an offensive term. It was replaced by the ‘politically correct’ terms ‘Negro’ and ‘Colored’ which were in turn replaced by ‘Afro-American’. Coming full cycle, Black with a capital b is now ‘politically correct’.

²⁴⁸ ‘Judge labels case ‘PC gone mad’’, *BBC News* (online), 6 April 2006
<http://news.bbc.co.uk/2/hi/uk_news/england/manchester/4883398.stm>.

²⁴⁹ Stephen M Quintana and Clark McKown (eds.), *Handbook of race, racism, and the developing child* (John Wiley & Sons, 2008

The judge's comments raise the question as to whether racist abuse in adults is socially unacceptable and should be sanctioned but in children it should be tolerated and kept free from sanction.

In Australia, political correctness is treated with a great deal of flexibility by both the right and left sides of government. Recently, the former Australian Prime Minister, Julia Gillard stated that she would not allow political correctness to get in her way when addressing immigration issues²⁵⁰ while the Opposition Leader, Tony Abbott recommitted to his potential future coalition government removing section 18C from the *Racial Discrimination Act* 1975 (Cth).²⁵¹ He implied that this section, that makes it illegal to make statements that offend based on race or ethnicity, is simply a 'hurt feelings' test.²⁵² He argued that '[e]xpression or advocacy should never be unlawful merely because it is offensive'²⁵³ and '[s]peech that has to be inoffensive is not free, just unerringly politically correct'.²⁵⁴ The clear message of Mr Abbott, the newly elected Australian Prime Minister is that while racial abuse is not socially acceptable, it should be socially tolerated. The problem is that when a society tolerates offensiveness, in due course offensiveness becomes acceptable and eventually, customary, a situation exemplified in regard to mental illness (see Section 6.0 below).

5.2 Immigration and political correctness

The earliest judicial use of the term 'politically correct' appears to be by U.S. Supreme Court Justice James Wilson in 1793 in *Chisholm v. Georgia* when he used the expression 'not politically correct' in order to reveal and criticise what he perceived as an inappropriate use of language.²⁵⁵ In 2010, the U.S. Supreme Court would again turn its attention to the inappropriate use of language when Justice Sotomayor chose to use alternative, 'politically correct' language in contrast to the language used by her fellow judges in *Chamber of Commerce of the United States*

²⁵⁰ 'PM vows no 'political correctness' on immigration', *SBS World News Australia* (online), 4 July 2010 <<http://www.sbs.com.au/news/article/1293687/pm-vows-no-political-correctness-on-immigration>>.

²⁵¹ James Massola 'Abbott slams 'political correctness enforcement agency'', *Financial Review* (online), 6 August 2012 <http://afr.com/p/national/abbott_slams_political_correctness_rApUF2bnf8Wwpdr2m56eIN>.

²⁵² Mariam Veiszadeh, 'Opinion: Abbott's pandering betrayal: Why the Racial Discrimination Act is worth defending', *ABC Religion and Ethics* (online), 13 August 2012 <<http://www.abc.net.au/religion/articles/2012/08/13/3566446.htm>>.

Mariam Veiszadeh is a lawyer, writer and community rights advocate

²⁵³ Massola, above n 251.

²⁵⁴ Ibid.

²⁵⁵ *Chisholm v. Georgia*, 2 U.S. (2 Dall.) 419 (1793).

v. *Whiting*.²⁵⁶ Previously, in what many perceived to be a historic moment, Justice Sotomayor had introduced the term ‘undocumented immigrant’,^{257 258} which was a label that was endorsed by the National Association of Hispanic Journalists (NAHJ), an organisation opposed to terminology that criminalises the person rather than the actual act of illegally entering or residing in the United States.²⁵⁹

NAHJ has always denounced the use of the degrading terms such as “alien” and “illegal alien” to describe undocumented immigrants because it casts them as adverse, strange beings, inhuman outsiders who come to the U.S. with questionable motivations. ‘Aliens’ is a bureaucratic term that should be avoided unless used in a quote.²⁶⁰

There has long been general acceptance by the courts, government agencies and public of the terms ‘illegal immigrants’ and ‘illegal aliens’ to identify people who entered, or reside in the United States without lawful authority. The presence of these individuals is classified as a violation of immigration law.²⁶¹ A growing number of scholarly and liberal voices²⁶² argue that the terms are ‘racially loaded, ambiguous, imprecise and pejorative’²⁶³ and claim that by ascribing illegality to a person’s alleged violation, for which the yet as unproved burden of proof rests with the government, is comparative to the criminal law labelling a suspect who has not

²⁵⁶ (December 8, 2010) (No. 09-115)

²⁵⁷ *Mohawk Industries, Inc. v. Carpenter* (12/08/2009) (08–678)

²⁵⁸ Debra Cassens Weiss, ‘Is It ‘Illegal’ or ‘Undocumented’ Immigrants? Sotomayor Opts for the Latter’ (2010) *American Bar Association Journal*

<http://www.abajournal.com/news/article/is_it_illegal_or_undocumented_immigrants_sotomayor_opts_for_the_latter>.

²⁵⁹ NAHJ Urges News Media to Stop Using the Term “Illegals” When Covering Immigration, National Association of Hispanic Journalists, Media Brief, Sept 15, 2009, <<http://www.marketwire.com/press-release/nahj-urges-news-media-to-stop-using-the-term-illegals-when-covering-immigration-1205765.htm>>

²⁶⁰ Ibid, Executive Director Iván Román.

²⁶¹ E.g. ‘U.S. Immigration and Customs Enforcement (ICE) officers today arrested hundreds of illegal aliens at Wal-Mart stores in more than 20 U.S ... Individuals who have violated U.S. Immigration laws by illegally entering and working in the United States are subject to arrest and removal from this country.’ Press Release, U.S. Department of Homeland Security, *Immigration and Customs Enforcement (ICE) Employment Investigation Yields Hundreds of Arrests* (Oct.23, 2003).

<<http://search.dhs.gov/search?query=Immigration+and+Customs+Enforcement+%28ICE%29+Employment+Investigation+Yields+Hundreds+of+Arrests&op=Search&affiliate=dhs>>

²⁶² Victor C Romero, ‘Racial Profiling: Driving While Mexican and Affirmative Action’ (2003) 6 *Michigan Journal of Race & Law* 195. n.11. See also Kevin R Johnson, “‘Aliens’ and the U.S. Immigration Laws: The Social and Legal Construction of Nonpersons’ (1996– 97) 28 *The University of Miami Inter-American Law Review* 263.

²⁶³ Beth Lyon, ‘When More “Security” Equals Less Workplace Safety: Reconsidering U.S. Laws That Disadvantage Unauthorized Workers’ (2004) 6 *University of Pennsylvania Journal of Labor and Employment Law* 571, 576.

been tried in court, a ‘convicted criminal’.²⁶⁴ Using the term ‘unauthorised’ is said to avoid the overbroad and criminal connotations associated with ‘illegal’.²⁶⁵

But it seems that ‘political correctness’ is a vacillating road to travel. In *Whiting*²⁶⁶, Sotomayor inexplicably altered her terminology to that of ‘undocumented aliens’ after having first corrected her initial use of the more pejorative ‘illegal aliens’.²⁶⁷ The relevant state and federal statutes refer to ‘unauthorized aliens’²⁶⁸ although the term ‘illegal alien’ is used in the *Immigration Reform and Control Act* of 1986 but with regard to the incarceration and deportation of convicted offenders. The Supreme Court absque Sotomayor chose to use the term ‘illegal aliens’. Sotomayor took the backward step into political incorrectness with her use of the term ‘alien’.

The negative perception of aliens as strange, inhuman outsiders requiring harsh and punitive measures can unquestionably influence courts. *Reno v Flores*²⁶⁹ demonstrates how members of the U.S. Supreme Court manipulated their use of terminology to reflect their favourable decision or to justify the harsh treatment of a vulnerable group of children. In rejecting the constitutional challenges, Justice Scalia referred to the children as ‘alien juveniles’ while Justice Stevens in his *contra* judgment simply called them ‘children’.²⁷⁰ The word ‘children’ is evocative of the natural desire to provide care and protection to a young, dependant person while juvenile is an exclusionary term suggestive of ‘juvenile delinquents’ and ‘juvenile courts’, and children or adolescents who demonstrate antisocial or illegal behaviours. This same language manipulation has been used in Australian cases.

5.3 Australian immigration and political correctness

In the years leading up to 2004, there had been a steady and striking rise in the immigration caseload of the Australian Federal Court. The number of cases filed had risen from 84 in 1987/8 to 1340 in 2000/01 and by 2002, 54 per cent of all

²⁶⁴ Ibid.

²⁶⁵ Ibid 578.

²⁶⁶ *Chamber of Commerce of the United States v. Whiting* (December 8, 2010) (No. 09-115).

²⁶⁷ ‘Ibid 14, ‘but you don’t disagree that Congress at least intended that if someone violated the Federal law and hired illegal aliens and was -- undocumented aliens and was found to have violated it, that the State can revoke their license, correct?’.

²⁶⁸ *Legal Arizona Workers Act*, Ariz. Rev. Stat. Ann. § 23-211 and the *Immigration Reform and Control Act* of 1986". (8 USC 110).

²⁶⁹ *Reno v. Flores*, 507 U.S. 292, 294 (1993).

²⁷⁰ Kevin R Johnson, “‘Aliens’ and the U.S. Immigration Laws: The Social and Legal Construction of Nonpersons” (1996– 97) 28 *The University of Miami Inter-American Law Review* 263, 280.

decisions of the Court at trial and full bench levels were immigration matters.²⁷¹

The High Court's caseload had also risen dramatically so that by August 2002, it was receiving new applications at an average rate of 17 per week.²⁷² The issue of immigration began to strain the relationship between the Australian government and the courts so that by 1998, the Minister for Immigration was accusing the judges of embarking 'on a frolic of their own'.²⁷³

In 2002, Prime Minister Howard, in response to the release of two High Court judgements,²⁷⁴ stated on national television that 'tribunals and courts often operate unfairly'.²⁷⁵ In what was quickly becoming a match of political lob and return, ministers accused judges of undermining the will of Parliament while the High Court rebuked Parliament for imposing on the Court, a 'great inconvenience'.²⁷⁶ The tension came to a head in 2004 in the matter of *Singh v Commonwealth*.²⁷⁷ The High Court had to decide if a six year old girl, notwithstanding her Indian citizenship and lack of Australian citizenship was, by virtue of the fact that she was born in Australia (albeit to non-citizens), not an alien and therefore, whether it was beyond the legislative competence of the Parliament to deport her. Similarly to *Reno v Flores*, language use reflected the judicial positions taken. The majority held that the child who they referred to as the 'plaintiff' was an alien within the meaning of s 51(xix) of the Constitution and subject to deportation. Justice McHugh in his dissenting decision referred to the child throughout as 'Ms Singh'.

During the same year, the issue of the detention of five children in *Minister for Immigration and Multicultural and Indigenous Affairs v B*²⁷⁸ further strained the relationship between the officers of three Australian courts and a federal government minister, and inflamed public opinion. The Family Court had ruled

²⁷¹ John McMillan, 'Judicial Restraint and Activism in Administrative Law' (2002) 30 *Federal Law Review* 335, 337–8.

²⁷² Ibid 338.

²⁷³ Philip Ruddock, 'Immigration Reform: The Unfinished Agenda' (Speech to National Press Club), reported in 'Ruddock Slams Courts for Ignoring Will of Parliament', Australian Current Law News, 19 March 1998.

<<http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpressrel%2FRP005%22>>

²⁷⁴ The High Court decisions of *Muin v Refugee Review Tribunal* [2002] HCA 30; (2002) 190 ALR 601; (2002) 76 ALJR 966 (8 August 2002) and *Lie v Refugee Review Tribunal* (2002) 76 ALJR 966 (190 ALR 601, or [2002] HCA 30) were both handed down by the Full Court on 8 August 2002

²⁷⁵ Gerard Henderson, 'Ruddock and Howard: tough cop and nice cop', *The Age* (online), 13 August 2002 <<http://www.theage.com.au/articles/2002/08/12/1029113893737.html>>.

²⁷⁶ *Re Refugee Review Tribunal; Ex parte Aala*, (2000) 204 CLR 82 at para. 133; see also *Re Minister for Immigration and Multicultural Affairs; Ex parte Durairajasingham*, (2000) 168 ALR 407 at para. 13; and *Abebe v. Commonwealth*, (1999) 197 CLR 510

²⁷⁷ HCA 43; (2004) 222 CLR 322; (2004) 209 ALR 355; (2004) 78 ALJR 1383 (9 September 2004)

²⁷⁸ HCA 20; 219 CLR 365; 206 ALR 130; 78 ALJR 737 (29 April 2004)

that the children should be released from the Baxter Detention Centre while their father argued his claim for asylum.²⁷⁹ After their release, Federal Court Justice Lander rebuked the Immigration Minister's extraordinary decision to declare the house the children were staying in, and the school that they attended as places of detention. Neither the carers nor the school staff had consented to being declared detention officers.²⁸⁰ The activist Family Court then received a stern judicial rebuff from the High Court which unanimously overruled its decision, reasoning that the Family Court did not have the jurisdiction to order the release of the children, or to make orders about their welfare.²⁸¹

5.3.1. *The media complaint*

The media covered the *Minister for Immigration and Multicultural and Indigenous Affairs v B*²⁸² case extensively with the Sydney Morning Herald reporting the story beneath the headline, Illegal immigrant children may not be sent home. A complaint was brought before the Australian Press Council concerning the newspaper's use of the term 'illegal immigrants' to describe people who arrived in Australia without the necessary migration documents or authority. The complainants argued that the term was factually incorrect and that the correct term is 'asylum seekers'.

'Illegal' means 'contrary to or forbidden by law'. It necessarily implies commission of an offence. It is inappropriate, and misleading, to characterise an act as illegal simply because it is not specifically authorised. It is all the more inappropriate where the relevant conduct is positively permitted under international conventions, and where it is used as a device to make it appear respectable to imprison the supposed illegals.²⁸³

The Council upheld the complaint and stated that the newspaper had acknowledged its use of an incorrect descriptor and that it should have used the 'preferred term' of

²⁷⁹ *HR & DR & Minister for Immigration and Multicultural and Indigenous Affairs* [2003] FamCA 616 (14 August 2003).

²⁸⁰ 'Vanstone child detention move 'extraordinary'', *The Sydney Morning Herald* (online), 30 April 2004 <<http://www.smh.com.au/articles/2004/04/30/1083224575768.html>>.

²⁸¹ *Minister for Immigration and Multicultural and Indigenous Affairs v B* [2004] HCA 20; 219 CLR 365; 206 ALR 130; 78 ALJR 737.

²⁸² HCA 20; 219 CLR 365; 206 ALR 130; 78 ALJR 737 (29 April 2004)

²⁸³ Extract from a letter written by Julian Burnside to Refugee Advocate, Ross Copeland and included in his correspondence with Jack Herman, Exec Secretary Australian Press Council dated May 28, 2004. <<http://www.safecom.org.au/illegals2.htm>>.

‘asylum seekers’.²⁸⁴ The Department of Immigration and Multicultural and Indigenous Affairs countered the Council’s decision with the argument that ‘illegal immigrant’ was in fact correct terminology.²⁸⁵

The sensitivity in some quarters to the use of the words ‘illegal’ or ‘unlawful’ or ‘unauthorised’ to describe asylum seekers arriving without Australia’s permission seems to have at its root vigorous attempts by some in the community to mislead the public into believing a myth that all unauthorised arrivals are asylum seekers and that all asylum seekers have a right to enter a country of choice without authority and therefore ‘can never be illegal’. This is just not true. The reality is clear in international law and has been made crystal clear by the High Court of Australia.²⁸⁶

The use of the word ‘illegal’ or ‘unlawful’ to describe asylum seekers entering a country without authority is standard international practice, not least by signatory states to the *Refugees Convention*²⁸⁷ because the Convention (Article 31) explicitly refers to the ‘illegal entry or presence’ of refugees who arrive in the territory of a country ‘without authorisation’.²⁸⁸ As their asylum claims had been reviewed and refused, they had ceased to become ‘asylum seekers’. By May 2011, *The Australian* newspaper was referring to asylum seekers who had been unsuccessful in their asylum claims as ‘failed refugees’.²⁸⁹

The media both informs and reflects public attitudes. People react differently when exposed to intensive media discussions of a social issue or event than if they are simply aware of the issue.²⁹⁰ An event portrayed through the media, especially television, is experienced by the viewer as being more real and more credible than the same event in real life. “Reality” at a distance has become authentic reality and

²⁸⁴ *Australian Press Council*, Adjudication No. 1242, (June 2004)

< http://www.immi.gov.au/media/letters/letters04/Press_Council_28_June.htm>

²⁸⁵ Ibid.

²⁸⁶ Ibid, Stewart Foster, Director, Public Affairs, Department of Immigration & Multicultural & Indigenous Affairs (Australia)

²⁸⁷ United Nations Convention Relating to the Status of Refugees, 1951, Resolution 2198 (XXI).

²⁸⁸ Stewart Foster, Director, Public Affairs DIMIA, Letter to the Editor ‘Illegal immigrant – correct terminology’, *The Australian Press Council* (online), 28 June 2004

<http://www.immi.gov.au/media/letters/letters04/Press_Council_28_June.htm>.

²⁸⁹ Paul Maley, ‘Dozens of failed ‘refugees’ still here’, *The Australian* (online), 4 May 2011

<<http://www.theaustralian.com.au/national-affairs/dozens-of-failed-refugees-still-here/story-fn59niix-1226049430046>>.

²⁹⁰ Margaret A Somerville, ‘Euthanasia in the Media: Journalists’ Values, Media Ethics and “Public Square” Messages’ (1997) 13 *Humane Health Care International* 17.

“real” reality has lost its value until it is authenticated through the media’.²⁹¹ The mediatisation of the immigration issue has succeeded in polarising the views of Australians but it has also given public dialogue to what is an important social conundrum.

5.3.2 *The political agenda*

In 2010, the former Australian Prime Minister, the Hon. Julia Gillard, vowed not to let political correctness interfere in tackling immigration ‘[s]o any sort of political correctness, or niceties that get in the way, I think, need to be swept out of the way.’²⁹² During a radio interview in August 2012, the Hon. Tony Abbott, then the former Leader of the Opposition and now current Prime Minister of Australia, referred to the numbers of ‘illegal arrivals’, to which the interviewer responded by saying ‘They’re not illegal. Tony Abbott, do I need to remind you that the use of words in this is critical?’²⁹³ Most recently, in October 2013, the newly appointed Minister for Immigration, Hon. Scott Morrison instructed his departmental staff to publicly refer to asylum seekers as ‘illegal’ arrivals rather than as clients. Critics claim the new terminology is designed to dehumanise and demonise refugees.²⁹⁴ The courts accept that the use of ‘unlawful non-citizen’ in the *Migration Act* 1958 is a labelling term and that ‘unlawful’ in the Australian sense has the rather meaningless definition of ‘without lawful permission’.²⁹⁵

Judicial decision-makers, government agents, and the media recognise the significance of language in manipulating public sentiments and attitudes on immigration matters. The language that is chosen in any given circumstance is dependent on the commentator’s values and biases which are often reflected in their political agenda. It is a useful tool for impressing attitudinal and behavioural population change favoured by governments and incorporated into law to combat prejudices including race and sexism. Equally, it is an ideology easily dismissed by governments when it is deemed inconvenient. But what the ‘asylum seeker’

²⁹¹ Ibid.

²⁹² ‘PM vows no ‘political correctness’ on immigration’, *SBS World News Australia* (online), 4 July 2010 <<http://www.sbs.com.au/news/article/1293687/pm-vows-no-political-correctness-on-immigration>>.

²⁹³ Barrie Cassidy, ‘A rare challenge to Abbott’s free pass’, *ABC The Drum* (online), 17 August 2012 <<http://www.abc.net.au/news/2012-08-17/cassidy-a-rare-challenge-for-abbott/4203120>>.

²⁹⁴ Bianca Hall, ‘Minister wants boat people called illegals’, *Sydney Morning Herald*, October 30, 2013.

²⁹⁵ Gummow, J. In *Behrooz & Ors v Secretary DIMIA & Ors, SHDB v Godwin & Ors, MIMIA v Al Khafaji* [2003] *HCATrans* 458 (13 November 2003)

issue has shown is that ‘political correctness’ can be a powerful stimulator of public and legal debate.

In mental health, sanism is not only hidden but it is also silent. There is no public debate regarding the offensiveness of sanist language but simply polite conversations amongst mental health stakeholders about whether terms such as ‘people experiencing mental illness’ is preferable to other terms such as ‘the mentally ill’. Rather than political and judicial strategic action to eradicate contemptuous and offensive language associated with mental illness from the public voice, governments have largely ignored its existence while the courts have largely accepted sanist language as socially acceptable.

6. SOCIALLY ACCEPTABLE OFFENSIVENESS

But if thought corrupts language, language can also corrupt thought.²⁹⁶

Derogatory language is a medium that is used to reflect the contempt of the normal majority for the inferior minority. Only in recent decades have societies, mostly, discontinued their legal and social exclusionist policies. These policies prevented people experiencing a mental illness from interacting with the ‘normal’ majority by authorising their detention in public institutions, or through the stigmatic ‘blame’ responses of families confining them within the family home and out of public view. As a consequence of the historical social distance between the groups, attitudinal and linguistic expressions of difference have flourished in the larger society unchecked. Pejorative terms including ‘crazy’, ‘bonkers’, ‘loony’, ‘nuts’ and ‘wacko’ entered into the vocabulary of ordinary language as did the more scientific, though no less pejorative terms such as ‘abnormal’, ‘insane’, ‘maniac’, ‘deviant’, ‘schizo’ and ‘psycho’.

That these terms are now embedded in common parlance is too often given as an excuse as to why there has been no real political or legal attempt to make their use unacceptable in ordinary language similar to the present legally and socially *non gratis* racially offensive words such as ‘nigger’ and ‘paki.’²⁹⁷ Once well established

²⁹⁶ George Orwell, *Collected Essays, Journalism & Letters of George Orwell*, (Harcourt, Brace and World, 1968), 137.

²⁹⁷ David Harrison and Jon Swaine, ‘Prince Harry’s ‘Paki’ comments ‘completely unacceptable’, says David Cameron’, *The Telegraph* (online), 11 January 2009

within general parlance, these strongly discredited terms are now classed as derogatory and highly offensive and their use is an actionable insult as a term of contempt.²⁹⁸ Social activists are focused on removing them from cultural and historical prominence.

‘Nigger is arguably the most known of the contemptuous terms, prompting editors recently, as a ‘political correct’ exercise, to expunge from Mark Twain’s classic anti-racist novel *Huckleberry Finn*, all occasions of the word and replacing it with ‘slave’.²⁹⁹

Dehumanizing language, when used in regard to people experiencing mental illness, is both ubiquitous and socially acceptable.³⁰⁰ One recent English study surveyed 400 14 year old schoolchildren, who provided the researchers with 250 different labels used to stigmatise people with a mental illness.³⁰¹ The labels were grouped into five themes of which the first and largest group consisted of 116 (almost half the total) labels termed ‘popular derogatory terms’: slang. They found that the labels appeared ‘to have no referent but were a set of negative associations and judgements in and of themselves.’³⁰² The primary sources identified for the derogatory references were the media³⁰³ and family and peers.³⁰⁴ Professor Patrick McGorry, leading international researcher, clinician, advocate for reform in mental health and 2010 Australian of the Year made the claim that ‘common gibes such as "nutter" and "psycho" reflected an inherent prejudice towards the mentally ill’³⁰⁵ and

<<http://www.telegraph.co.uk/news/uknews/theroyalfamily/4216808/Prince-Harrys-Paki-comments-completely-unacceptable-says-David-Cameron.html>>.

²⁹⁸ Vivian Anne de Klerk, ‘A nigger in the woodpile? A racist incident on a South African University campus’ (2011) 2 *Journal of Languages and Culture* 39.

²⁹⁹ ‘Censoring Mark Twain’s ‘n-words’ is unacceptable’, *The Guardian* (online), 5 January 2011

<<http://www.guardian.co.uk/books/booksblog/2011/jan/05/censoring-mark-twain-n-word-unacceptable>>.

³⁰⁰ Hinshaw and Stier, above n 9. See also Stephen P Hinshaw and Dante Cicchetti, ‘Stigma and mental disorder: Conceptions of illness, public attitudes, personal disclosure, and social policy’ (2000) 12 *Development and Psychopathology* 555.

³⁰¹ Diana Rose *et al.*, ‘250 labels used to stigmatise people with mental illness’ (Research Paper, *British Medical Council Health Services*, 2007)<<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1925070/pdf/1472-6963-7-97.pdf>>.

³⁰² Ibid.

³⁰³ Otto F Wahl, ‘Depictions of mental illness in children’s media’ (2003) 12 *Journal of Mental Health* 49. See also Ann K Adler and Otto F Wahl, ‘Children’s beliefs about people labelled mentally ill’ (1998) 68 *American Journal of Orthopsychiatry* 321.

³⁰⁴ Ann K Adler and Otto F Wahl, ‘Children’s beliefs about people labelled mentally ill’ (1998) 68 *American Journal of Orthopsychiatry* 321.

³⁰⁵ Mark Metherell, ‘Mental health failure tied to prejudice: McGorry’, *The Age* (online), 23 June 2010 <<http://www.theage.com.au/national/mental-health-failure-tied-to-prejudice-mcgorry-20100622-yvuf.html>>.

that society's broad acceptance of discriminatory language suggests the obvious, that mental illness prejudice and stigma still operates at all levels.³⁰⁶

6.1 Political correctness in mental health

Proclaimed as a key factor in the 'successful' campaigns opposing discrimination based on race, gender, age, disability and religion, 'politically correct' language was promoted as being equally applicable to mental health, with the attached implication that similar successful results would be achieved.³⁰⁷ There is a concern that 'political correctness' in mental health has come with a cost.³⁰⁸ An example is the use of the label 'mental health consumer' in preference to the pejorative label 'schizophrenic'. Critics suggest that this can have a negative impact by suggesting that the person's symptoms are under their control, raising the expectation that the person should, and can, effect personal change.³⁰⁹ If a change does not occur, then individual and public frustration will.³¹⁰

Euphemistic labels such as 'person with a mental illness' or 'mental health consumer' are claimed to carry an insufficiency of information that results in the public filling in the gaps with the undesirable effect of increasing stigma through stereotypical associations with concepts of dangerousness, unpredictability and uncontrollability.³¹¹ The use of the term 'person with schizophrenia' is said to be preferred by the cohort of individuals who actually experience this particular illness.³¹² But when a person is continually paired with a particular mental illness, 'politically correct' terms can take on stigmatising properties to the extent that the 'politically correct' term, 'person with a severe mental illness' becomes no less pejorative than 'person with schizophrenia' or even 'schizophrenic'.³¹³ This raises the question of how relevant is a descriptor when mental illness and schizophrenia are inextricably entwined in the public mind.

³⁰⁶ Ibid.

³⁰⁷ S R Adhikari, 'Mental Illness and Stigma' (2007) 5 *Kathmandu University Medical Journal* 293.

³⁰⁸ David L Penn and Amy Nowlin-Drummond, 'Politically Correct Labels and Schizophrenia: A Rose by Any Other Name' (2001) 27 *Schizophrenia Bulletin* 197.

³⁰⁹ Ibid 202.

³¹⁰ Ibid 201.

³¹¹ Ibid 202.

³¹² Don't dis me with that language – The disability language A – Z guide, NSW Government Department of Ageing, Disability and Home Care, 2010, < <http://www.docstoc.com/docs/33415467/Dont-dis-me-with-that-language-%E2%80%94-The-disability-language-A---Z-guide>>

³¹³ Penn and Nowlin-Drummond, above n 308, 202.

The entrenchment of the disease model has meant the embrace of scientific terms such as ‘mental disorder’ and ‘brain disorder’, and mental illness described as a medical condition.³¹⁴ Science rejects the use of vague and value laden terms in favour of precisely-definable, morally neutral terms. This use of physiological or biological terminology was wrongly thought to decrease stigmatisation because of the perception of mental illness as a ‘real’ medical problem.³¹⁵ As discussed in Chapter Three, many commentators consider the medical model to be oppressive, and that the ‘sick role’ patient is made dependent and incapable, and that their obligation to take care of their own affairs is cancelled. They are dehumanised within the disease paradigm.³¹⁶

6.2 Political correctness and sanism

Language is a common communication method that enables the transmission of intended and unintended meanings. Language which is unclear in its message or has unintended stigmatising meanings is particularly insidious and dangerous because those messages and meanings become so common place as to be invisible.³¹⁷ This invisibility is woven into the social acceptability of the prejudice associated with mental illness so strongly argued by Michael Perlin in his theory of sanism, discussed at length in Chapter Five.

In the recent psycho/legal response³¹⁸ to the Australian Capital Territory’s 2010 Options Paper: Review of the *Mental Health (Treatment and Care) Act 1994*³¹⁹, the authors advised readers that their decision to adopt the:

³¹⁴ The National Association for the Mentally Ill, <http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm>

³¹⁵ Mona M Shattell, ‘Stigmatizing Language with Unintended Meanings: “Persons with Mental Illness” or “Mentally Ill Persons”?’ (2009) 30 *Issues in Mental Health Nursing* 199.

³¹⁶ Jerry Alan Winter, ‘The Development of the Disability Rights Movement as a Social Problem Solver’ (2003) 23 *Disability Studies Quarterly* 33.

³¹⁷ Shattell, above n 315.

³¹⁸ The Response was the combined contribution of two senior psychiatrists and a lawyer. Dr Christopher James Ryan MBBS FRANZCP, Consultation=Liaison Psychiatrist, Westmead Hospital, Westmead NSW and Senior Clinical Lecturer, Discipline of Psychiatry and the Centre for Values, Ethics and the Law in Medicine, University of Sydney. Sascha Callaghan BEc (Soc Sci) LLB (Hons), Solicitor and Barrister, Supreme Court of New South Wales & the Australian Capital Territory and Research Scholar, Centre for Values Ethics & the Law in Medicine, University of Sydney. Dr Matthew Large MBBS FRANZCP, Senior Staff Specialist Psychiatrist and Conjoint Senior Lecturer, The Prince of Wales Hospitals and the University of New South Wales.

³¹⁹ ‘Response to Review of the Mental Health (Treatment and Care) Act 1994: The Framework of Mental Health and Related Legislation in the ACT’ (An Options Paper, Mental Health Community Coalition ACT, 2010) <http://www.mhccact.org.au/cms/media/user_uploads/publications_submissions/MH%20ACT%20Legislative%20Framework%20Options.pdf>.

rather clumsy term “people living with a mental illness” rather than use more euphonious signifiers like “the mentally ill” was due to their belief that much of the debate originates from the entrenched and largely invisible prejudice against people who suffer mental illness which Michael Perlin has dubbed ‘sanism’.³²⁰

The authors stated that an intrinsic part of sanism is that people who ‘happen to suffer a mental illness’³²¹ are perceived to be essentially different from the rest of society. They are effectively defined by their illness to their detriment, akin to the use of the term ‘the Negro’.³²² The main problem with broad-brush terms like ‘the mentally ill’ is that they lump all kinds of people with all kinds of mental health conditions into one impersonal mass,³²³ however, referring to people as ‘living with mental illness’ rather than being ‘mentally ill’ is unlikely to purge from the public mind the entrenched belief that they are still people who are essentially different. The person continues to be labelled and defined by their mental illness. And the preferred label, ‘living with’, in fact, suggests a degree of choice, much like living with an unsuitable flat mate or a badly behaved pet: fix it and if you can’t fix it, move out or move on.

Sanism is ‘based predominately on ... deindividualization’³²⁴ which raises the argument as to whether using the term ‘people’ may contribute to a person’s loss of individual self-awareness. Also, the authors’ use of the term ‘suffer’ which means to feel pain or distress; sustain loss, injury, harm, or punishment, tolerate or endure evil, injury, pain, or death or appear disadvantaged³²⁵ may be a reflection of the authors’ own ‘entrenched and largely invisible prejudice’³²⁶ which may be a counter weight their good intentions. Mental health advocates argue that clichés such as ‘suffering from’ or ‘afflicted with’ perpetuate misunderstanding and fears about being diagnosed with a mental illness, and that with treatment and support, ‘most

³²⁰ Ibid 4 no. 6.

³²¹ Ibid.

³²² Ibid.

³²³ Sue Lockett John, ‘Word choices matter when reporting on people with mental illnesses’ (Feature, School of Social Work University of Washington, 2013

<http://depts.washington.edu/mhreport/features/word_choices_matter.php>.

³²⁴ Michael L Perlin, *The Hidden Prejudice: Mental Disability on Trial* (American Psychological Association, 2000) xix.

³²⁵ Answers, American Heritage Dictionary, <<http://www.answers.com/topic/suffer>>

³²⁶ Mental Health Community Coalition ACT, above n 319, 4 no 6.

people with mental illness diagnoses are managing their symptoms and leading ordinary, productive lives.’³²⁷

It appears that the authors have confused ‘political correctness’ with sanism, perhaps believing, as many others do, that if the text contains ‘politically correct’ language, it is evidence of the writer’s lack of prejudice. Unfortunately, substituting the term ‘people living with a mental illness’ for ‘mentally ill’, only to then reduce the epithet to the acronym ‘PLWMI’ throughout the remainder of the document, does not succeed as a linguistic demonstration of value and respect being shown to people who have a mental illness. This type of acronymic use is offensive when referring to marginalised groups.

This is made particularly evident in, for example, an indigenous discussion where ‘[t]he term ‘Aboriginal’ should never be abbreviated, as to do so is offensive’.³²⁸ Also ‘[t]he abbreviation to ‘ATSI’ when used to describe people is offensive’³²⁹ and ‘[t]he term ‘Torres Strait Islander’ should never be abbreviated, as to do so is offensive’.³³⁰ It would not be acceptable to refer to the First Nations Peoples as FNPs or to African-Americans as AAs in any public document of note and yet the use of PLWMI was considered in this instance to be an acceptable, non-prejudicial use of language.

The authors’ suggestion that it ‘may be sensible to adopt such terminology to protect their rights’ was also not convincing. Their numerous references to suffering³³¹ are reflective of a patronising use of language.³³² The attribution of ‘sanism’ as justification for the authors’ use of ‘politically correct language’ may well be demonstrable of sanism at work, with these authors, and perhaps many others, failing to recognise their own acceptance of that which should be unacceptable in a confused homage to political correctness rather than sanism.

³²⁷ Lockett John, above n 114.

³²⁸ ‘Guidelines for Aboriginal and Torres Strait Islander Terminology’ (Guidelines, Queensland Health, October 2011) 2 <<http://www.health.qld.gov.au/atsihealth/documents/terminology.pdf>>.

³²⁹ Ibid.

³³⁰ Ibid 3.

³³¹ Genelle Sharrock, ‘The Media, Mental Health Issues and The CALD Community’ (Slides, Mindframe), <http://www.ceh.org.au/downloads/Diversity_in_Health/Presentations/Day1_A063_Sharrock.pdf>. ‘Say “being treated for” or “currently experiencing” a mental illness rather than “suffering from” or “afflicted with” a mental illness’

³³² ‘Patronising language - Don’t describe people as brave, special or suffering just because they have a disability.’ Also, ‘Sufferer - Avoid using to indiscriminately describe a person with a disability – individuals don’t suffer just because they have a disability.’ Above n 313.

Simply using people-first language will not change underlying negative attitudes often hidden or unrecognised behind a sanist curtain of acceptability. Using ‘politically correct’ language may give the impression that discrimination and prejudice are being tackled head on but often it is a case of applying a sanist veneer that is sufficient to settle most interested minds but which effects very little actual, positive change for people experiencing mental illness.

6.3 Mental illness and the law’s acceptance of socially offensive language

In 1998, David Hay, Auckland’s Deputy Mayor, lodged a complaint with the New Zealand Broadcasting Standards Authority in which he claimed that Television New Zealand had breached Standard G13 of the Television Code of Broadcasting Practice³³³ when a presenter called him a ‘moron’, a term he found offensive.³³⁴ In reaching its decision, the Authority referenced two dictionary definitions for the word³³⁵:

- 1 *colloq* a very stupid or foolish person
- 2 an adult with a mental age of about 8 – 12

In declining to uphold the complaint, the Authority reasoned that ‘the colloquial use of the word moron is not uncommon in general parlance in New Zealand’³³⁶ and was only ‘marginally derogatory’.³³⁷ This raises the question as to how the Authority decided that calling a city official a very stupid or foolish person would not detract significantly from their good character, and particularly from their civic standing as the continuation of their role is reliant on the election support of the public. The court found that ‘although it involved the use of a marginally derogatory colloquial expression, it was an ‘expression of a genuinely-held opinion in a news or current affairs programme’³³⁸ and therefore exempt.³³⁹ Elucidating the issue in a later, different complaint, the Authority, stated that it:

³³³ *Broadcasting Act 1989* (NZ), The Free-to-Air Television Code of Broadcasting Practice, Standard 7(a)

³³⁴ *David Hay Deputy Mayor of Auckland, Complaint against Broadcaster Television New Zealand Limited – Broadcasting Standards Authority - 1998-043* [1998] NZBSA 38 (30 April 1998) <<http://bsa.govt.nz/decisions/716-decision-number-1998-043>>.

³³⁵ *The Concise Oxford Dictionary*, (Clarendon Press, Eighth Edition, 1990).

³³⁶ *Ibid.*

³³⁷ *Ibid.*

³³⁸ *Ibid.*

³³⁹ G13(ii)

reiterates the conclusion it reached in its earlier decision which was that it is not unfair to describe someone as a ‘moron’ in view of the accepted, relatively light-hearted colloquial meaning given to the term in New Zealand.³⁴⁰

‘Moron’ is a eugenic term first used in psychology ‘to denote a particular measure of feeble-mindedness and low intelligence.’³⁴¹ It sat within a list of other, newly scientific terms such as imbecile³⁴² and idiot.³⁴³ A broad application of the Binet – Simon Scale³⁴⁴ revealed that the intelligence level of almost half the population of America sat within the moronic category.³⁴⁵ This empirical fact did not sit well with the population, which led to the various terms of classification subsequently being disused as scientific terms and helped in all of them being used as common insults in general language.³⁴⁶

The Authority’s decision suggests that even though a word is offensive in its genesis and meaning, and the speaker might use the word with the intention of offending, and the person against whom the word is used may feel deeply offended, both personally and professionally, because the offensive term is in use in ordinary language, the aggrieved person has little remedy in the courts. Following this reasoning, the past acceptable colloquial use of subjectively measured derogatory terms such as ‘nigger’ and ‘piccaninny’ might not legitimate their present use but if it were not for the public’s acceptance of the offensiveness of the words and the

³⁴⁰ *Jenny Hale of Auckland Broadcaster Television New Zealand Limited - 1998-079* [1998] NZBSA 76 (23 July 1998)

³⁴¹ The word ‘moron’ was widely introduced by Henry Herbert Goddard as scientific terminology to describe people with a mental age between 8 and 12. Goddard was a eugenicist who was focused on preventing the breeding of feeble-minded people. In 1908, he had found utility in mental testing as a way to evidence the superiority of the white race. After studying abroad, he brought the Binet-Simon Scale to the United States and had it translated into English. Goddard believed that compulsory sterilization would solve the problem of feeble-mindedness, a proposition he understood that many would find offensive, so as an alternative, he suggested that mentally deficient individuals should be kept, humanely, in institutions. His best known work is *The Kallikak Family: A study in the heredity of feeble-mindedness*. (Macmillan, 1912). In 1914, he became the first American psychologist to testify in court that subnormal intelligence should limit the criminal responsibility of defendants.

³⁴² A person whose intelligence has been tested at a level between the ages of three to seven on the Binet scale.

³⁴³ A person whose intelligence has been tested at a level below the age of three on the Binet scale.

³⁴⁴ Alfred Binet, ‘New Methods for the Diagnosis of the Intellectual Level of Subnormals’ (1905) 12 *L’Année Psychologique* 191 <<http://psychclassics.yorku.ca/Binet/binet1.htm>>. The following translation by Elizabeth S. Kite first appeared in *The development of intelligence in children*, Vineland, NJ: Publications of the Training School at Vineland, in 1916. ‘Understanding the normal progress of intellectual development among normals, we shall be able to determine how many years such an individual is advanced or retarded. In a word we shall be able to determine to what degrees of the scale idiocy, imbecility, and moronity correspond’.

³⁴⁵ Jean-Claude Croizet, *The Racism of Intelligence: How Mental Testing Practices Have Constituted an Institutionalized Form of Group Domination*. In Henry Lewis Gates et al (eds), *The Oxford Handbook of African American Citizenship, 1865-Present* (Oxford University Press, 2012).

³⁴⁶ Trent W James, *Inventing the Feeble Mind: A History of Mental Retardation in the United States* (University of California Press, 1995).

presence of racial discrimination legislation³⁴⁷ regulating and sanctioning their use, the racially person would be without legal redress. The vast majority of stigmatising and offensive language associated with marginalised groups was at times in history acceptable in their use amongst the more powerful groups. Today, this type of judicial justification would likely only be considered to be adequate when the alleged offensive word/s pertained to mental illness.

The consequence for people who have a mental illness who live in a society in which people who do not have a mental illness are referred to by words and terms associated with mental illness is that they are hurt by the disregard of their feelings by the use of disparaging references.³⁴⁸ It is acceptable to laughingly call a friend crazy, nuts or psycho; lovingly call a child ‘a little lunatic’ or a ‘mad monster’; affectionately tell an elderly mother she’s ‘daft’ or call a father a ‘madman’ because he thinks a certain football team will win; or use the same words in anger when wanting to insult another person. Insensitive or offensive racial language is not socially acceptable. Insensitive or offensive sanist language has meshed into every aspect of our social fabric.

7. CONCLUSION

Sixty years of stigma studies have persistently arrived at the singular conclusion that the public’s attitudes toward people experiencing a mental illness are negative and rejecting, and formed out of fear and loathing.³⁴⁹ Contemporary assessments of popular sentiments indicate that the past injurious evaluations have not diminished, remaining prevalent within public attitudes,³⁵⁰ with certain types of negative beliefs having, in fact, increased.³⁵¹ Typically, society’s reaction to mental illness has been

³⁴⁷ *Racial Discrimination Act 1975*.

³⁴⁸ Otto F Wahl, ‘Confronting Stigma, Health Care and Rehabilitation Services’ (Committee Paper, Health Care and Rehabilitation Services, 2007)

<http://www.hcrs.org/index.php?option=com_content&view=article&id=198&Itemid=229>.

³⁴⁹ Jum C Nunnally, *Popular conceptions of mental health: Their development and change* (Holt, Rinehart & Winston, 1961).

³⁵⁰ Arthur H Crisp *et al.*, ‘Stigmatisation of people with mental illnesses’ (2000) 177 *The British Journal of Psychiatry* 4. This study found that the stigmatising opinions about people with psychiatric disorders are still widely held in the population and concluded that if stigma is to be reduced, more needs to be done than providing information about mental disorders. There must also be an attempt to reduce discrimination. See also Graham Thornicroft, *Shunned: Discrimination against people with mental illness* (Oxford University Press, 2006).

³⁵¹ Jim Read and Sue Baker, ‘Not Just Sticks and Stones: A survey of the stigma, taboos and discrimination experienced by people with mental health problems’ (Report, The Mental Health Charity, November 1996) 2 <<http://www.leeds.ac.uk/disabilitystudies/archiveuk/MIND/MIND.pdf>>.

one of denial, isolation, and insulation³⁵² so that stereotypes, prejudice, discrimination, social barriers, and social rejection continue to be confronted by people who experience mental illness.³⁵³

Chapter Four examined the approaches of science, protest, education, anti-discrimination laws, inclusive public policies and cultural interventions; all the tools intended to decrease, if not eradicate entirely, society's differential treatment of people experiencing a mental illness. However, it is clear that these interventions have had limited success and in some instances, increases rather than decreases in negative attitudes have been reported.³⁵⁴ Public attitudes have proven themselves to be extraordinarily resistant to change.

The health policy strategy of educating the public to the view that mental illness is an 'illness like any other' has been successful, although the public's greater understanding and appreciation of the aetiology and symptoms/signs of mental illness has not resulted in the anticipated stigma diffusion. Instead, the 'disease' model had the unintended result of increasing mental illness stigma in regard to its association with violence, a fundamental element at the core of public fear.

In addition, this chapter has examined the position that the 'nature' of mental illness is largely a social phenomenon that is defined by the person's social behaviour and also the social impact that their behaviour has on people's lives because, unlike somatic illnesses, there are no physiological signs or symptoms for most mental illnesses.³⁵⁵ The chapter addressed this social/environmental aspect of mental illness in its examination of the shifting blame debate of nature and nurture which continues to strongly influence mental health policies, research and law. The nurture effect is particularly noteworthy in the area of family law parenting matters which will be discussed in Chapter Six. In this area of law, the instrument of fear is risk, a barrier that a parent with a mental illness is often unable to overcome. The nature effect can be found in the rapid technological advances that are increasingly being used to shift responsibility away from the person across to a pin pointed brain image. While this new technology may have advantages in sentencing for example,

³⁵² Barry Trute and Anne Loewen, 'Public Attitude Toward the Mentally Ill as a Function of Prior Experience' (1978) 13 *Social Psychiatry* 79.

³⁵³ Matthias C Angermeyer and Herbert Matschinger, 'Social distance towards the mentally ill: results of representative surveys in the Federal Republic of Germany' (1997) 27 *Psychological Medicine* 131.

³⁵⁴ Phelan *et al.*, above n 16.

³⁵⁵ Len Bowers, *The Social Nature of Mental Illness* (Routledge, 1998) 2.

it may equally have disadvantages in its use in preventive sentencing. The nature effect also reinforces the view that a person with mental illness lacks control over their behaviour, a significant contributing factor to the public's fear and desire for social distance.

Finally, this chapter examined the cultural intervention of 'political correctness', an ideology that promotes language that is not disrespectful or used to exclude disadvantaged groups from fully participating in all aspects of society. The ideology is founded on a set of democratic values and a principle - fairness, justice and equality – that are expected to coexist congruently alongside another, conflicting set of deeply felt, socially entrenched negative attitudes about mental illness. The incongruence of the situation is exemplified by state authorities' willingness to publically discard the ideology when it is incompatible with a political agenda as evidenced by the immigration discussion, or judicial validation of the use of derogatory and offensive language that is associated with mental illness because of its embeddedness in common parlance. But what is absolutely clear is the public's knowledge that should it publically use language such as 'nigger' or 'Paki', there will be social condemnation and legal punishment. This is not the case when a person experiencing mental illness is called a 'lunatic', 'moron' and 'loony'.

Chapter Four has shown that there is a wealth of research that defines, describes, and measures the impact of social stigma on people's lives. It has also shown that there is an equally plentiful amount of research reporting that anti-stigma strategies, in particular anti-discrimination legislation, which regulates and sanctions language and behaviour, have succeeded in altering how the public acts although not necessarily how it thinks and feels when discussing social issues such as racism. Unfortunately, even these limited successes have not been repeated in the area of mental health. The prejudice associated with mental illness is institutionalised, ingrained into Australian culture, and according to Perlin, it is often unseen, or unrecognised by those that should know better: the policymakers, legislators and judicial decision-makers. Perlin considers that the legal system's blindness to the stigmatisation and discrimination that it attaches to mental illness is a reflection of sanism, the insidious force discussed in Chapter Five. It is difficult, if not impossible, to challenge and change that which is largely invisible, and socially acceptable.

BIBLIOGRAPHY

A Articles

- Adhikari, S R 'Mental Illness and Stigma' (2007) 5 *Kathmandu University Medical Journal* 293.
- Adler, Ann K, and Otto F Wahl, 'Children's beliefs about people labelled mentally ill' (1998) 68 *American Journal of Orthopsychiatry* 321.
- Andrews, Edna, 'Cultural Sensitivity and Political Correctness: The Linguistic Problem of Naming' (1996) 71 *American Speech* 389.
- Angermeyer, Matthias C, and Herbert Matschinger, 'Causal beliefs and attitudes to people with schizophrenia: Trend analysis based on data from two population surveys in Germany' (2005) 186 *British Journal of Psychiatry* 331.
- Angermeyer, Matthias C, and Herbert Matschinger, 'Social distance towards the mentally ill: results of representative surveys in the Federal Republic of Germany' (1997) 27 *Psychological Medicine* 131.
- Appelbaum, Paul S, 'Law & Psychiatry: Behavioral Genetics and the Punishment of Crime' (2005) 56 *Psychiatric Services* 25.
- Bar-Levav, Reuven, 'The stigma of seeing a psychiatrist' (1976) 30 *American Journal of Psychotherapy* 473.
- Begg, E J, 'Prescribing in pregnancy and lactation' (2008) 65 *British Journal of Clinical Pharmacology* 627.
- Binet, Alfred, 'New Methods for the Diagnosis of the Intellectual Level of Subnormals' (1905) 12 *L'Année Psychologique* 191.
- Blume, John H, and Emily C Paavola, 'Life, Death, and Neuroimaging: The Advantages and Disadvantages of the Defense's Use of Neuroimages in Capital Cases – Lessons from the Front' (Research Paper Series No 11-18, Cornell Law School, 23 May 2011) <http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1856188>.
- Brockington, Ian F, Peter Hall, Jenny Levings, and Christopher Murphy, 'The community's tolerance of the mentally ill' (1993) 162 *British Journal of Psychiatry* 93.
- Chaiklin, Harris, 'Attitudes, Behaviour, and Social Practice' (2011) 38 *Journal of Sociology and Social Welfare* 31.
- Corrigan, Patrick W, 'Where Is the Evidence Supporting Public Service Announcements to Eliminate Mental Illness Stigma?' (2012) 63 *Psychiatric Services* 79.
- Corrigan, Patrick W, and Amy C Watson, 'Understanding the impact of stigma on people with mental illness' (2002) 1 *World Psychiatry* 16.
- Corrigan, Patrick W, and David L Penn, 'Lessons from social psychology on discrediting psychiatric stigma' (1999) 54 *American Psychologist* 765.
- Corrigan, Patrick W, and Jenessa R Shapiro, 'Measuring the Impact of Programs that Challenge the Public Stigma of Mental Illness' (2010) 30 *Clinical Psychology Review* 907.

- Corrigan, Patrick W, *et al.*, 'Mental illness stigma: problem of public health or social justice?' (2005) 50 *Social Work* 363.
- Corrigan, Patrick W, *et al.*, 'Three strategies for changing attributions about severe mental illness' (2001) 27 *Schizophrenia Bulletin* 187.
- Corrigan, Patrick W, 'How Stigma Interferes With Mental Health Care' (2004) 59 *American Psychologist* 614.
- Corrigan, Patrick W, 'Target-specific stigma change: A strategy for impacting mental illness stigma' (2004) 28 *Psychiatric Rehabilitation Journal* 113.
- Corrigan, Patrick W, Fred E Markowitz, and Amy C Watson, 'Structural levels of mental illness stigma and discrimination' (2004) *Schizophrenia Bulletin* 481.
- Crisp, Arthur, *et al.*, 'Stigmatisation of people with mental illnesses: a follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists' (2005) 4 *World Psychiatry* 106.
- Crisp, Arthur H, *et al.*, 'Stigmatisation of people with mental illnesses' (2000) 177 *The British Journal of Psychiatry* 4.
- de Klerk, Vivian Anne, 'A nigger in the woodpile? A racist incident on a South African University campus' (2011) 2 *Journal of Languages and Culture* 39.
- Dockery, Terry M, and Arthur G Bedesian, 'Attitude versus actions: LaPiere's (1934) classic study revisited' (1989) 17 *Social Behavior and Personality* 9.
- Elizabeth Peel, 'Editorial Introduction: Recognizing and Celebrating Same-Sex Relationships: Beyond the Normative Debate' (2008) 11 *Sexualities* 659.
- Evans-Lacko, Sara, *et al.*, 'Evaluation of a brief anti-stigma campaign in Cambridge: do short-term campaigns work?' (2010) 10 *Biomed Central Public Health* 339.
- Fairchild, Halford H, 'Black, Negro, or Afro-American?: The Differences Are Crucial!' (1985) 16 *Journal of Black Studies* 47.
- Feigenson, Neal, 'Brain imaging and courtroom evidence: on the admissibility and persuasiveness of fMRI' (2006) 2 *International Journal of Law in Context* 233.
- Foster, Juliet, 'Unification and differentiation: A study of social representations of mental illness' (2001) 10 *Papers on Social Representations* 1.
- Funk, Michelle, *et al.*, 'Advocacy for mental health: roles for consumer and family organizations and governments' (2006) 21 *Health Promotion International* 70.
- Geser, Hans, 'Political Correctness: mental disorder, childish fad or advance of human civilization?' (2008) (online publication) *Sociology in Switzerland*, <http://www.forschungsnetzwerk.at/downloadpub/Political_Correctness_pc_geser2008.pdf>.
- Giner-Sorolla, Roger *et al.*, 'Shame expressions reduce the recipient's insult from outgroup reparations' (2008) 44 *Journal of Experimental Social Psychology* 519.
- Hayes, Robert A, and Christopher Vaughan, 'Stigma directed toward chronic illness is resistant to change through education and exposure' (2002) 90 *Psychology Reporter* 1161.

Hegerl, Ulrich and Lisa Wittenburg, 'Focus on mental health care reforms in Europe: the European alliance against depression: a multilevel approach to the prevention of suicidal behaviour' (2009) 60 *Psychiatric Services* 596.

Heijnders, Miriam, and Suzanne Van Der Meij, 'The fight against stigma: an overview of stigma reduction strategies and interventions' (2006) 11 *Psychology Health and Medicine*, 353.

Henderson, Anita, 'What's in a Slur?' (2003) 78 *American Speech* 52.

Hess, Volker, and Benoît Majerus, 'Writing the history of psychiatry in the 20th century' (2011) 22 *History of Psychiatry* 139.

Hinshaw, Stephen P, and Andrea Stier, 'Stigma as Related to Mental Disorders' (2008) 4 *Annual Review of Clinical Psychology* 367.

Hinshaw, Stephen P, and Dante Cicchetti, 'Stigma and mental disorder: Conceptions of illness, public attitudes, personal disclosure, and social policy' (2000) 12 *Development and Psychopathology* 555.

Holmes, Paul E, *et al.*, 'Changing attitudes about schizophrenia' (1999) 25 *Schizophrenia Bulletin* 447.

Jeff Johnson, 'Literature, Political Correctness and Cultural Equity' (1992) 8 *English Today: The International Review of the English Language* 44.

Jennifer Grafton and Joanne M Lye, 'Political correctness, surface tension & passive racism' (2000) 19 *Youth Studies Australia* 44.

Johnson, Dale L, 'Schizophrenia as a brain disease: implications for psychologists and families' (1989) 44 *American Psychologist* 553.

Johnson, Kevin R, "'Aliens" and the U.S. Immigration Laws: The Social and Legal Construction of Nonpersons' (1996– 97) 28 *The University of Miami Inter-American Law Review* 263.

Jones, Owen D, *et al.*, 'Brain Imaging for Legal Thinkers: A Guide for the Perplexed' (2003) 5 *Stanford Technology Law Review*
<<http://stlr.stanford.edu.ezproxy.utas.edu.au/pdf/jones-brain-imaging.pdf>>.

Jorm, Anthony F, *et al.*, 'Mental health literacy: A survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment' (1997) 166 *Medical Journal of Australia* 182.

Jorm, Anthony F, Helen Christensen, and Kathleen M Griffiths, 'The impact of beyondblue: the national depression initiative on the Australian public's recognition of depression and beliefs about treatments' (2005) 39 *Australian and New Zealand Journal of Psychiatry* 248.

Keane, Mary, 'Acceptance vs. rejection: nursing students' attitudes about mental illness' (1991) 27 *Perspectives in Psychiatric Care* 13.

Kelly, Claire M, Anthony F Jorm, and Annemarie Wright, 'Improving mental health literacy as a strategy to facilitate early intervention for mental disorders' (2007) 187 *Medical Journal of Australia* 26.

Keyzer, Patrick, 'The United Nations Human Rights Committee's views about the legitimate parameters of the preventive detention of serious sex offenders' (2010) 34 *Criminal Law Journal* 283.

Khoshbin, Laura Stephens, and Shahram Khoshbin, 'Imaging the Mind, Minding the Image: An Historical Introduction to Brain Imaging and the Law' (2007) 33 *American Journal of Law and Medicine* 171.

Klotz, Peter, 'Politeness and Political Correctness: Ideological Implications' (1999) 9 *Pragmatics* 155.

Kolodziej, Monika E and Blair T Johnson, 'Interpersonal contact and acceptance of persons with psychiatric disorders: a research synthesis' (1996) 64 *Journal of Consulting and Clinical Psychology* 387.

Large, Matthew M, *et al.*, 'The Predictive Value of Risk Categorization in Schizophrenia' (2011) 19 *Harvard Review of Psychiatry* 25.

Large, Matthew, Olav Nielssen, and Gordon Elliott, 'Reliability of psychiatric evidence in serious criminal matters: fitness to stand trial and the defence of mental illness' (2009) 43 *Australian and New Zealand Journal of Psychiatry* 446.

Lidz, Charles W, Edward P Mulvey, and William Gardner, 'The accuracy of predictions of violence to others' (1993) 269 *Journal of American Medical Association* 1007.

Lind, William S "'Political Correctness: A Short History of an Ideology' (Research Paper, Free Congress Foundation, November 2004)
<<http://www.scribd.com/doc/2674655/Political-Correctness-A-Short-History>>.

Link, Bruce G, and Jo C Phelan, 'Conceptualizing Stigma' (2001) 27 *Annual Review of Sociology* 363.

Lyon, Beth, 'When More "Security" Equals Less Workplace Safety: Reconsidering U.S. Laws That Disadvantage Unauthorized Workers' (2004) 6 *University of Pennsylvania Journal of Labor and Employment Law* 571.

McMillan, John, 'Judicial Restraint and Activism in Administrative Law' (2002) 30 *Federal Law Review* 335.

Mehta, Sheila and Farina Amerigo, 'Is Being "Sick" Really Better? Effect of the Disease View of Mental Disorder on Stigma' (1997) 16 *Journal of Social and Clinical Psychology* 405.

Merton, Robert K, 'The Self-Fulfilling Prophecy' (1948) 8 *The Antioch Review* 193.

Monteith, Margo J, Jeffrey W Sherman, and Patricia G Devine, 'Suppression as a stereotype control strategy' (1998) 2 *Personality and Social Psychology Review* 63.

Moriarty, Jane Campbell, 'Flickering Admissibility: Neuroimaging Evidence in the U.S. Courts' (2008) 26 *Behavioral Sciences and the Law* 29.

Morrison, J K, J J Coccozza, and D Vanderwyst, 'An attempt to change the negative, stigmatizing image of mental patients through brief re-education' (1980) 47 *Psychological Reports* 334.

Ng, Petrus, and Kai-Fong Chan, 'Attitudes towards people with mental illness, Effects of a training program for secondary school students' (2002) 14 *International Journal of Adolescent Medical Health* 215.

Norton, Michael I, *et al.*, 'Color Blindness and Interracial Interaction: Playing the Political Correctness Game' (2006) 17 *Psychological Science* 949.

Payton, Andrew R, and Peggy A Thoits, 'Medicalization, Direct-to-Consumer Advertising, and Mental Illness Stigma' (2011) 1 *Society and Mental Health* 55.

Pedersen, Anne, *et al.*, 'Attitudes toward Aboriginal Australians in city and country settings' (2000) 35 *Australian Psychologist* 109.

Penn, David L, and Amy Nowlin-Drummond, 'Politically Correct Labels and Schizophrenia: A Rose by Any Other Name' (2001) 27 *Schizophrenia Bulletin* 197.

Penn, David L, and Bruce Link, 'Dispelling the stigma of schizophrenia, III: The role of target gender, laboratory-induced contact, and factual information' (2002) 6 *Psychiatric Rehabilitation Skills* 255.

Penn, David L, and Patrick W Corrigan, 'The effects of stereotype suppression on psychiatric stigma' (2002) 55 *Schizophrenia Research* 269.

Penn, David L, and Shannon M Couture, 'Strategies for reducing stigma toward persons with mental illness' (2002) 1 *World Psychiatry* 20.

Perlin, Michael L, "'Good and Bad, I Defined These Terms, Quite Clear No Doubt Somehow": Neuroimaging and Competency to be Executed after Panetti' (2010) 28 *Behavioral Sciences and the Law* 671.

Pescosolido, Bernice A, *et al.*, "'A disease like any other'": A decade of change in public reactions to schizophrenia, depression, and alcohol dependence' (2010) 167 *American Journal of Psychiatry* 1321.

Pescosolido, Bernice A, *et al.*, 'The "Backbone" of Stigma: Identifying the Global Core of Public Prejudice Associated with Mental Illness' (2013) 103 *American Journal of Public Health* 853.

Peter Byrne, 'Psychiatric stigma' (2001) 178 *The British Journal of Psychiatry* 281.

Peter Byrne, 'Stigma of mental illness and ways of diminishing it' (2000) 6 *Advances in Psychiatric Treatment* 65.

Phelan, Jo C, *et al.*, 'Public conceptions of mental illness in 1950 and 1996: what is mental illness and is it to be feared?' (2000) 41 *Journal of Health and Social Behavior* 188.

Phelan, Jo C, 'Genetic bases of mental illness – a cure for stigma?' (2002) 25 *Trends in Neurosciences* 430.

Phelan, Jo C, Rosangely Cruz-rojas, and Marian Reiff, 'Genes and Stigma: The Connection Between Perceived Genetic Etiology and Attitudes and Beliefs About Mental Illness' (2002) 6 *Psychiatric Rehabilitation Skills* 159.

Pinfold, Vanessa, *et al.*, 'Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools' (2003) 182 *The British Journal of Psychiatry* 342.

- Pinker, Steven, 'Why nature & nurture won't go away' (2004) 133 *Daedalus* 5.
- Pinto-Foltz, Melissa D, and M Cynthia Logsdon, 'Reducing Stigma Related to Mental Disorders: Initiatives, Interventions, and Recommendations for Nursing' (2009) 23 *Archives of Psychiatric Nursing* 32.
- Poyraz, Suzan, 'The Charge of Thought-Policing in Universities' (2006) 36 *The Canadian Journal of Higher Education* 65.
- Procter, Nicholas G, "'They first killed his heart (then) he took his own life': Reaching out, connecting and responding as key enablers for mental health service provision to multicultural Australia' (2006) 5 *Advances in Mental Health* 81.
- Read, John, and Alan Law, 'The relationship between causal *beliefs and contact with users of mental health services to attitudes to the 'mentally ill''* (1999) 45 *International Journal of Social Psychiatry* 216.
- Read, John and Niki Harre, 'The role of biological and genetic causal beliefs in the stigmatisation of 'mental patients'' (2001) 10 *Journal of Mental Health* 223.
- Read, John, 'Why promoting biological ideology increases prejudice against people labelled "schizophrenic"' (2007) 42 *Australian Psychologist* 118.
- Reddy, I R S, 'Making psychiatry a household word' (2007) 49 *Indian Journal of Psychiatry* 10.
- Reeves, Donald, *et al.*, 'Limitations of Brain Imaging in Forensic Psychiatry' (2003) 31 *Journal of American Academy of Psychiatry and Law* 89.
- Robin J Ely, Martin N Davidson, and Debra Meyerson, 'Rethinking Political Correctness' (2006) 84 *Harvard Business Review* 78.
- Romero, Victor C, 'Racial Profiling: Driving While Mexican and Affirmative Action' (2003) 6 *Michigan Journal of Race & Law* 195.
- Rothaus, Paul, 'Describing psychiatric hospitalization: A dilemma' (1963) 18 *The American Psychologist* 85.
- Rutter, Michael, 'Maternal Deprivation Reconsidered' (1972) 16 *Journal of Psychosomatic Research* 241.
- Schnittker, Jason, 'An uncertain revolution: Why the rise of a genetic model of mental illness has not increased tolerance' (2008) 67 *Social Science and Medicine* 1370.
- Schomerus, Georg *et al.*, 'Evolution of Public Attitudes about Mental Illness: A Systematic Review and Meta-Analysis' (2012) 125 *Acta Psychiatrica Scandinavica* 440.
- Schomerus, Georg, Herbert Matschinger, and Matthias C Angermeyer, 'Preferences of the public regarding cutbacks in expenditure for patient care: Are there indications of discrimination against those with mental disorders?' (2006) 41 *Social psychiatry and psychiatric epidemiology* 369.
- Schulze, Beate, and Matthias C Angermeyer, 'Subjective experiences of stigma. A focus group study of schizophrenic patients, their relatives and mental health professionals' (2003) 56 *Social Science & Medicine* 299.

- Schwartz, Richard A, and Ilze K Schwartz, 'Reducing the stigma of mental illness' (1977) 38 *Diseases of the Nervous System* 101.
- Scott, Joan Wallach, 'The Campaign Against Political Correctness: What's Really at Stake' (1992) 54 *Radical History Review* 59.
- Shattell, Mona M, 'Stigmatizing Language with Unintended Meanings: "Persons with Mental Illness" or "Mentally Ill Persons"?' (2009) 30 *Issues in Mental Health Nursing* 199.
- Martha Shenton, Thomas J Whitford and Marek Kubicki, 'Structural neuroimaging in schizophrenia from methods to insights to treatments' (2010) 12 *Dialogues in clinical neuroscience* 317.
- Shimmin, Carolyn 'Understanding stigma through a gender lens' (2009) 11 *Canadian Women's Health Network* 14.
- Simon, Robert I, 'The Myth of "Imminent" Violence in Psychiatry and the Law' (2006) 75 *University Of Cincinnati Law Review* 631.
- Sinnott-Armstrong, Walter, *et al.*, 'Brain Images as Legal Evidence' (2008) 5 *Episteme* 359.
- Skene, Loane, 'Neuroimaging and the Withdrawal of Life-Sustaining Treatment from Patients in Vegetative State' (2009) 17 *Medical Law Review* 245.
- Smith, Michael, 'Stigma' (2002) 8 *Advances in Psychiatric Treatment* 317.
- Somerville, Margaret A, 'Euthanasia in the Media: Journalists' Values, Media Ethics and "Public Square" Messages' (1997) 13 *Humane Health Care International* 17.
- Sommer, Robert, 'Family advocacy and the mental health system: The recent rise of the alliance for the mentally ill' (1990) 61 *Psychiatric Quarterly* 205.
- Sparrow, Robert, 'Talking sense about political correctness' (2002) 26 *Journal of Australian Studies* 119.
- Spitzer, Robert L, 'The diagnostic status of homosexuality in DSM-III: a reformulation of the issues' (1981) 138 *American Journal of Psychiatry* 210.
- Stuart, Heather, 'Fighting Stigma caused by mental disorders: past perspective, present activities, and future directions' (2008) 7 *World Psychiatry* 185.
- Szasz, Thomas S, 'The Lying Truths of Psychiatry' (1979) 3 *The Journal Of Libertarian Studies* 121.
- Szasz, Thomas, 'Psychiatry and the control of dangerousness: on the apotropaic function of the term "mental illness"' (2003) 29 *Journal of Medical Ethics* 227.
- Thachuk, Angela K, 'Stigma and the politics of biomedical models of mental illness' (2011) 4 *International Journal of Feminist Approaches to Bioethics* 140.
- Thornicroft, Graham *et al.*, 'Stigma: ignorance, prejudice or discrimination?' (2007) 190 *The British Journal of Psychiatry* 192.
- Torrey, E Fuller, 'Stigma and Violence: Isn't It Time to Connect the Dots?' (2011) 37 *Schizophrenia Bulletin* 892.

Trute, Barry and Anne Loewen, 'Public Attitude Toward the Mentally Ill as a Function of Prior Experience' (1978) 13 *Social Psychiatry* 79.

Vinestock, Morris, 'Risk assessment: A word to the wise?' (1996) 2 *Advances in Psychiatric Treatment* 3.

Wahl, Otto F, 'Depictions of mental illness in children's media' (2003) 12 *Journal of Mental Health* 49.

Warner, Kate, 'Sentencing Review 2002-2003' (2003) 27 *Criminal Law Journal* 325.

Watson, Amy C, 'Changing Middle Schoolers' Attitudes About Mental Illness Through Education' (2004) 30 *Schizophrenia Bulletin* 563.

Weiss, Debra Cassens, 'Is It 'Illegal' or 'Undocumented' Immigrants? Sotomayor Opts for the Latter' (2010) *American Bar Association Journal*
<http://www.abajournal.com/news/article/is_it_illegal_or_undocumented_immigrants_sotomayor_opts_for_the_latter>.

Winter, Jerry Alan, 'The Development of the Disability Rights Movement as a Social Problem Solver' (2003) 23 *Disability Studies Quarterly* 33.

Wolff, Geoffrey, *et al.*, 'Community Knowledge of Mental Illness and Reaction to Mentally Ill People' (1996) 168 *The British Journal of Psychiatry* 191.

Yamaguchi, Sosei, Yoshio Mino and Shahir Uddin, 'Strategies and future attempts to reduce stigmatisation and increase awareness of mental health problems among young people: a narrative review of educational interventions', (2011) 65 *Psychiatry and clinical neurosciences* 405.

Yung, Corey Rayburn, 'Symposium: Preventative Detention: Sex Offender Exceptionalism and Preventive Detention' (2011) 101 *Journal of Criminal Law and Criminology* 969.

B Book

Alloy, Lauren B, John H Riskind, and Margaret J Manos, *Abnormal Psychology: Current Perspectives* (McGraw-Hill, 9th ed, 2005).

Barlow, David H, and Vincent M Durand, *Abnormal Psychology: An Integrative Approach* (Wadsworth Cengage Learning, 2011).

Beauchaine, Theodore P, and Stephen P Hinshaw (eds), *Child and Adolescent Psychopathology* (Wiley, 2008).

Bowers, Len, *The Social Nature of Mental Illness* (Routledge, 1998).

Cohen, David B, *Stranger in the Nest: Do Parents Really Shape Their Child's Personality, Intelligence, or Character* (John Wiley and Sons, 1999).

Corrigan, Patrick W, (ed), *On the stigma of mental illness: Practical strategies for research and social change* (American Psychological Association, 2005).

Corrigan, Patrick W, David Roe, and Hector W H Tsang, *Challenging the Stigma of Mental Illness: Lessons for Therapists and Advocates* (John Wiley and Sons, 2011).

- Ewen, Robert B, *An Introduction to Theories of Personality*, (Lawrence Erlbaum and Associates, 2003).
- Gates, Henry Lewis, *et al.* (eds), *The Oxford Handbook of African American Citizenship, 1865-Present* (Oxford University Press, 2012).
- Goddard, Henry Herbert, *The Kallikak Family: A study in the heredity of feeble-mindedness*. (Macmillan, 1912).
- Goldberg, David, and Peter Huxley, *Common mental disorders a bio-social model'* (Routledge, 1992).
- Illes, Judy, (ed), *Neuroethics: Defining the Issues in Theory, Practice and Policy* (Oxford University Press, 2005).
- Jones, Edward E, *et al.*, *Social Stigma: The Psychology of Marked Relationships* (W.H. Freeman, 1984).
- McSherry, Bernadette, and Patrick Keyzer, *Sex Offenders and Preventive Detention: Politics, Policy and Practice* (Federation Press, 2009).
- Nadel, Lynn, (ed), *Encyclopedia of Cognitive Science* (Nature Publishing, 2002)
- Nunnally, Jum C, *Popular conceptions of mental health: Their development and change* (Holt, Rinehart & Winston, 1961).
- Orwell, George, *Collected Essays, Journalism & Letters of George Orwell*, (Harcourt, Brace and World, 1968).
- Perlin, Michael L, *The Hidden Prejudice: Mental Disability on Trial* (American Psychological Association, 2000).
- Quintana, Stephen M, and Clark McKown (eds.), *Handbook of race, racism, and the developing child* (John Wiley & Sons, 2008).
- Robinson, Daniel N, *Praise and Blame* (Princeton University Press, 2002).
- Simpson, Joseph R, (ed), *Neuroimaging in Forensic Psychiatry: From Clinic to the Courtroom* (Wiley-Blackwell, 2012).
- Spranger, Tade Mathias, (ed), *International Neurolaw: A Comparative Analysis* (Springer, 2012).
- Thornicroft, Graham, *Shunned: Discrimination against people with mental illness* (Oxford University Press, 2006).
- Trent W James, *Inventing the Feeble Mind: A History of Mental Retardation in the United States* (University of California Press, 1995).
- van Dongen, Els, and Sylvie Fainzang (eds), *Lying and Illness: Power and Performance* (Het Spinhuis, 2005).
- Wahl, Otto E, *Media Madness: Public images of mental illness* (Rutgers University Press, 1995).

Weiner, Bernard, *Judgments of Responsibility: A Foundation for a Theory of Social Conduct* (Guilford Press, 1995).

**C. Grey Literature -Research Papers, Reports, Submissions, Letters, Memos
etc**

Burnside, Julian, (Letter, Australian Press Council, 2004)
<<http://www.safecom.org.au/illegals2.htm>>.

‘Changing Behaviour: A Public Policy Perspective’ (Research Paper, Australian Public Service Commission, 2007),
<http://www.apsc.gov.au/__data/assets/pdf_file/0017/6821/changingbehaviour.pdf>.

‘Cosmetic anti-stigma campaigns miss the point’ (2012) 4 *NSSS Advocacy Bulletin*
<<http://www.northshoreschizophrenia.org/images/2012%20Feb%20Advocacy%20Bulletin.pdf>>.

‘Discrimination against people with experiences of mental illness’ (Discussion Paper, Mental Health Commission, 1997)
<<http://www.hdc.org.nz/media/200685/discrimination%20against%20people%20with%20experiences%20of%20mental%20illness%20july%201997.pdf>>.

‘Ending Stigma and Achieving Parity in Mental Health: A Physician Perspective’ (Summary of Presentations and Key Emerging Themes, Canadian Medical Association *et al.*, 2010)
<<http://www.mooddisorderscanada.ca/documents/Advocacy/Stigma%20Workshop%20Report.pdf>>.

‘Guidelines for Aboriginal and Torres Strait Islander Terminology’ (Guidelines, Queensland Health, October 2011)
<<http://www.health.qld.gov.au/atsihealth/documents/terminology.pdf>>.

‘National Survey of Mental Health and Wellbeing: Summary of Results’ (Report, Australian Bureau of Statistics, 2007)
<<http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4326.0Media%20Release12007?opendocument&tabname=Summary&prodno=4326.0&issue=2007&num=&view=>>>.

‘Response to Review of the Mental Health (Treatment and Care) Act 1994: The Framework of Mental Health and Related Legislation in the ACT’ (An Options Paper, Mental Health Community Coalition ACT, 2010)

‘Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings’
<http://www.mhccact.org.au/cms/media/user_uploads/publications_submissions/MH%20ACT%20Legislative%20Framework%20Options.pdf>.

2009 National Survey on Drug Use and Health: Volume I (Summary of National Findings, U.S. Department of Health And Human Services, 2010)
<<http://oas.samhsa.gov/NSDUH/2k9NSDUH/2k9Results.htm>>.

‘Attitudes to Mental Illness’ (Research Report, U.K. Department of Health, 2007)
<http://webarchive.nationalarchives.gov.uk/20120406161400/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_076516>.

‘Attitudes to Mental Illness’ (Research Report, U.K. Department of Health, 2010)
 <http://webarchive.nationalarchives.gov.uk/20120502171823/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_114795>.

Don't dis me with that language – The disability language A – Z Guide, Promotional material, NSW Government Department of Ageing, Disability and Home Care, 2010) <<http://www.docstoc.com/docs/33415467/Dont-dis-me-with-that-language-%E2%80%94The-disability-language-A---Z-guide>>.

Everett, Barbara, ‘Stigma: The Hidden Killer’ (Background Paper and Literature Review, Mood Disorders Society of Canada, 2006)
 <<http://www.mooddorderscanada.ca/documents/Publications/Stigma%20the%20hidden%20killer.pdf>>.

Francis, Catherine, *et al.*, ‘Improving Mental Health Literacy: A Review of the Literature’ (Literature Review, Centre for Health Program and Evaluation Evidence, 2002)
 <[http://quitnow.gov.au/internet/main/publishing.nsf/Content/6A5554955150A9B9CA2571FF0005184D/\\$File/literacy.pdf](http://quitnow.gov.au/internet/main/publishing.nsf/Content/6A5554955150A9B9CA2571FF0005184D/$File/literacy.pdf)>.

Health Report Wave 2 - *Views and Understanding of Schizophrenia and Bipolar Disorder in Australia*, (Stollznow Pfizer website, 2010),
 (<http://www.pfizer.com.au/sites/au/news_and_media/media_releases/Pages/StigmaofseverementalillnessescontinuestoriseinAustralia.aspx>.

Hunter, David J, and Amanda Killoran, ‘Tackling health inequalities: turning policy into practice?’ (U.K. Health Development Agency, 2004)
 <<http://www.nice.org.uk/nicemedia/documents/tacklinghealthinequalities.pdf>>

John, Sue Lockett ‘Word choices matter when reporting on people with mental illnesses’ (Feature, School of Social Work University of Washington, 2013)
 <http://depts.washington.edu/mhreport/features/word_choices_matter.php>.

Martin, Neasa, ‘From Discrimination to Social Inclusion: A Review of the literature on anti stigma initiatives in mental health (Report, Queensland Alliance, 2009)
 <<http://www.mhcc.org.au/documents/From-discrimination-to-social-inclusion-Lit-review.pdf>>.

McMillan, John, ‘Immigration and the Law Chapter 5 Upholding the Australian Constitution’ (Paper, Samuel Griffith Society Conference, 2002).

‘Mental Health’ (A Report of the U.S. Surgeon General, 1999)
 <<http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBHS>>

Myers, Fiona, *et al.*, ‘Evaluation Of ‘See Me’ - The National Scottish Campaign Against Stigma and Discrimination Associated with Mental Ill-Health’ (Report, Scottish Government Social Research, 2009)
 <http://ec.europa.eu/health/mental_health/eu_compass/reports_studies/seeme_report.pdf>.

Nugent, Kirsten, ‘Neuroimaging in Criminal Trials: Evidentiary and Constitutional Concerns’ (Research Paper, Seleted Works, January 2009)
 <http://works.bepress.com/kristen_nugent/4>.

Read, Jim, and Sue Baker, ‘Not Just Sticks and Stones: A survey of the stigma, taboos and discrimination experienced by people with mental health problems’ (Report, The Mental Health Charity, November 1996)
 <<http://www.leeds.ac.uk/disabilitystudies/archiveuk/MIND/MIND.pdf>>.

Report, United States Department Of Health And Human Services, 2010,
<http://www.samhsa.gov/data/NSDUH/2k10MH_Findings/2k10MHResults.htm>.

Roberts, Richard, 'Shaming, State Power, and Enforcement in the History of Anti-Trafficking Efforts: African Perspectives' (Working Paper No 006, Program on Human Rights Centre on Democracy, Development, and the Rule of Law, 2012) <http://iis-db.stanford.edu/pubs/23749/Roberts_Shaming_Final_06_13_13.pdf>.

Rose, Diana *et al.*, '250 labels used to stigmatise people with mental illness' (Research Paper, British Medical Council Health Services Research, 2007)
<<http://www.biomedcentral.com/content/pdf/1472-6963-7-97.pdf>>.

Sharrock, Genelle, 'The Media, Mental Health Issues and The CALD Community' (Slides, Mindframe),
<http://www.ceh.org.au/downloads/Diversity_in_Health/Presentations/Day1_A063_Sharrock.pdf>.

Stein, Jo, 'HIV/AIDS Stigma: The Latest Dirty Secret' (Working Paper No 46, Centre for Social Science Research University of Cape Town, 2003) <<http://www.heart-intl.net/HEART/010105/HIVAIDSSigmaTh.pdf>>.

The White House at Work, The Clinton-Gore Administration: Addressing Mental Health, Monday, June 7, 1999 <<http://clinton2.nara.gov/WH/Work/060799.html>>

United States Census, 2010, U.S. Department Of Commerce, Economics and Statistics Administration, U.S. Census Bureau < <http://www.census.gov/2010census/>>

Wahl, Otto F, 'Confronting Stigma, Health Care and Rehabilitation Services' (Committee Paper, Health Care and Rehabilitation Services, 2007)
<http://www.hcrs.org/index.php?option=com_content&view=article&id=198&Itemid=229>.

D. International law instruments

United Nations Convention relating to the Status of Refugees, 1951, Resolution 2198 (XXI).\

E. Legislation and Regulations

Age Discrimination Act 2004 (Cth).

Australian Human Rights Commission Act 1986 (Cth).

Broadcasting Act 1989 (NZ).

Disability Discrimination Act 1992 (Cth).

Immigration Reform and Control Act of 1986. (8 USC 110).

Racial Discrimination Act 1975 (Cth).

Sex Discrimination Act 1984 (Cth).

The Free-to-Air Television, Code of Broadcasting Practice.

F. Cases

Abebe v. Commonwealth, (1999) 197 CLR 510.

Australian Press Council, Adjudication No. 1242, (June 2004).

Behrooz & Ors v Secretary DIMIA & Ors, SHDB v Godwin & Ors, MIMIA v Al Khafaji [2003] HCATrans 458.

Bruce Lindsay Maguire v. Sydney Organising Committee for the Olympic Games (Respondent) H 99/115 (2000).

Burgess v Leech [2007] NSWSC 700.

Fardon v Attorney-General (Qld) (2004) 223 CLR 575

Hagan v Trustees of the Toowoomba Sports Ground Trust [2000] FCA 1615.

Hickie v Hunt and Hunt [1998] HREOCA 8.

HR & DR & Minister for Immigration and Multicultural and Indigenous Affairs [2003] FamCA 616.

Lie v Refugee Review Tribunal [2002] HCA 30).

Mabo v Queensland (No 2) [1992] HCA 23.

Mabo v Queensland (No. 1) (1988) 166 CLR 186.

McBain v Victoria (2000) 99 FCR 116.

Minister for Immigration and Multicultural and Indigenous Affairs v B [2004] HCA 20.

Muin v Refugee Review Tribunal [2002] HCA 30.

R v Coleman [2010] 9NSWSC 177.

R v Jeong Ming Foo [2008] NSWSC 587.

R v KT [2007] NSWSC 83.

Re Minister for Immigration and Multicultural Affairs; Ex parte Durairajasingham, (2000) 168 ALR 407

Re Refugee Review Tribunal; Ex parte Aala, (2000) 204 CLR 82.

Singh v Commonwealth HCA 43.

Tabet v Gett [2010] HCA 12.

Brown v. Board of Education of Topeka, 347 U.S. 483 (1954).

Chamber of Commerce of the United States v. Whiting (December 8, 2010) (No. 09-115).

Chisholm v. Georgia, 2 U.S. (2 Dall.) 419 (1793).

David Hay Deputy Mayor of Auckland, Complaint against Broadcaster Television New Zealand Limited – Broadcasting Standards Authority - 1998-043 [1998] NZBSA 38 (30 April 1998).

Gillick v West Norfolk and Wisbech Area Health Authority [1985] 3 All ER 402 (HL).

HJ (Iran) (FC) v Secretary of State for the Home Department [2010] UKSC 31

Jenny Hale of Auckland Broadcaster Television New Zealand Limited - 1998-079 [1998] NZBSA 76 (23 July 1998).

Lawrence v Texas, 539 U.S. 558 (2003).

Legal Arizona Workers Act, Ariz. Rev. Stat. Ann. § 23-211.

Loving v. Virginia, 388 U.S. 1 (1967).

Mohawk Industries, Inc. v. Carpenter (12/08/2009) (08–678).

O'Connor v. Donaldson, 422 U.S. 563 (1975).

R v R [1992] 1 A.C. 599, House of Lords.

Reno v. Flores, 507 U.S. 292, 294 (1993).

Roe v. Wade, 410 U.S. 113 (1973).

Roper v. Simmons, 543 U.S. 551 (2005) (No.03–633).

G. Media and websites

‘Censoring Mark Twain's 'n-words' is unacceptable’ (*The Guardian*, 6 January, 2011) <<http://www.guardian.co.uk/books/booksblog/2011/jan/05/censoring-mark-twain-n-word-unacceptable>>.

‘Immigration and Customs Enforcement (ICE) Employment Investigation Yields Hundreds of Arrests’ (Press Release, U.S. Department of Homeland Security, October 23, 2003). <<http://search.dhs.gov/search?query=Immigration+and+Customs+Enforcement+%28ICE%29+Employment+Investigation+Yields+Hundreds+of+Arrests&op=Search&affiliate=dhs>>.

‘Judge labels case 'PC gone mad'’ (*BBC News*, April 6, 2006) <http://news.bbc.co.uk/2/hi/uk_news/england/manchester/4883398.stm>.

‘NAHJ Urges News Media to Stop Using the Term “Illegals” When Covering Immigration’, (Media Brief, National Association of Hispanic Journalists, September 15, 2009) <<http://www.marketwire.com/press-release/nahj-urges-news-media-to-stop-using-the-term-illegals-when-covering-immigration-1205765.htm>>.

‘PM vows no ‘political correctness’ on immigration’ (*SBS World News Australia*, 4 July, 2010) <<http://www.sbs.com.au/news/article/1293687/pm-vows-no-political-correctness-on-immigration>>.

‘Vanstone child detention move 'extraordinary'’ (*The Sydney Morning Herald*, April 30, 2004) <<http://www.smh.com.au/articles/2004/04/30/1083224575768.html>>.

Better Health Channel, (Website, Victorian Department of Health, 2012)
<http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Mental_health_problems_early_care_helps>.

Bleifuss, Joel, 'A Politically Correct Lexicon' (*In These Times*, February, 2007)
<http://www.inthesetimes.com/article/3027/a_politically_correct_lexicon/>.

Cassidy, Barrie, 'A rare challenge to Abbott's free pass' (*ABC The Drum*, August 17, 2012)
<<http://www.abc.net.au/news/2012-08-17/cassidy-a-rare-challenge-for-abbott/4203120>>.

Coleman, Peter, 'What is Political Correctness? The Pros and Cons' (*Quadrant*, 2000)
<<http://www.liberalindia.com/relevance/PoliticalCorrectness.php>>.

Corliss, Richard, 'Appreciation: Charlton Heston' (*Time*, 6 April, 2008)
<<http://www.time.com/time/arts/article/0,8599,1728272-3,00.html>>.

Department of Health and Ageing website,
<<http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-w-whatmen-toc~mental-pubs-w-whatmen-myth>>

Foster, Stewart, 'Illegal immigrant – correct terminology' (Letter to the Editor, 2004)
<http://www.immi.gov.au/media/letters/letters04/Press_Council_28_June.htm>.

Hall, Bianca 'Minister wants boat people called illegals', *Sydney Morning Herald*, October 30, 2013.

Harrison, David and Jon Swaine, 'Prince Harry's 'Paki' comments 'completely unacceptable', says David Cameron' (*The Telegraph*, January 11, 2009)
<<http://www.telegraph.co.uk/news/uknews/theroyalfamily/4216808/Prince-Harrys-Paki-comments-completely-unacceptable-says-David-Cameron.html>>.

Henderson, Gerard, 'Ruddock and Howard: tough cop and nice cop' (*The Age*, August 13, 2002) <<http://www.theage.com.au/articles/2002/08/12/1029113893737.html>>.

Hewlett, Jason 'Legal system needs to stick to law, retired Supreme Court judge says', (*The Daily News*, January 18, 2013)
<<http://www.kamloopsnews.ca/article/20130118/KAMLOOPS0101/130119821/-1/kamloops/legal-system-needs-to-stick-to-law-retired-supreme-court-judge-says>>.

Maley, Paul, 'Dozens of failed 'refugees' still here' (*The Australian*, May 4, 2011)
<<http://www.theaustralian.com.au/national-affairs/dozens-of-failed-refugees-still-here/story-fn59niix-1226049430046>>.

Martin, Jack 'Census Bureau defends 'negro' addition' (*The New York Daily News*, January 6, 2010) <http://www.upi.com/Top_News/US/2010/01/06/Census-Bureau-defends-negro-addition/UPI-70241262798663/>.

Massola, James, 'Abbott slams 'political correctness enforcement agency'' (*Financial Review*, 6 August, 2012) <http://afr.com/p/national/abbott_slams_political_correctness_rApUF2bnf8Wwpdr2m56eIN>.

Metherell, Mark, 'Mental health failure tied to prejudice: McGorry' (*The Age*, 23 June, 2010) <<http://www.theage.com.au/national/mental-health-failure-tied-to-prejudice-mcgorry-20100622-yvuf.html>>.

Porter, Janet Street 'Depression? It's just the new trendy illness!' (*Daily Mail*, 5 August, 2010) <<http://www.dailymail.co.uk/debate/article-1278510/Depression-Its-just-new-trendy-illness.html>>.

Quirk, Clark, 'Family violence court cases rise 20 per cent' (*The Standard*, July 28, 2012) <<http://www.standard.net.au/story/967113/family-violence-court-cases-rise-20-per-cent/>>.

Ruddock, Philip, 'Ruddock Slams Courts for Ignoring Will of Parliament' (*Australian Current Law News*, 18 March, 1998) <<http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpressrel%2FRP005%22>>.

The National Association for the Mentally Ill website, <http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm>

Toynbee, Polly, 'This bold equality push is just what we needed. In 1997' (*The Guardian*, 28 April, 2009) <<http://www.guardian.co.uk/commentisfree/2009/apr/28/toynbee-equality-bill-welfare>>.

Veiszadeh, Mariam, 'Opinion: Abbott's pandering betrayal: Why the Racial Discrimination Act is worth defending' (*ABC Religion and Ethics*, 13 August, 2012) <<http://www.abc.net.au/religion/articles/2012/08/13/3566446.htm>>.

CHAPTER FIVE

THE CONTROVERSIAL CONCEPTS OF SANISM AND PRETEXTUALITY

1. INTRODUCTION

*Science must begin with myths, and with the criticism of myths.*¹

Chapters One and Two discussed the problems that underlie the way the legal system operates in situations in which mental illness is a key factor. Nebulous or contradictory mental health concepts, ambiguous and inconsistent terminology, and an overreliance on one particular paradigm - the biomedical model - have succeeded in creating an unhelpful policy environment and a poor statutory basis for legal actors to operate. Chapter Three examined the phenomenon of stigma; the social construct of stereotypes, prejudice and discrimination that is both the source, and the product, of the problems that were discussed in the first two chapters. Stigma exemplifies the fact that law is not just words on paper but is transformed by its implementation into public attitudes and social practices.²

Chapter Four showed that stigma associated with mental illness is pervasive, and despite policy, legal and cultural interventions, remains resistant to change. This was particularly evidenced by the law's acceptance of insulting words and terms that would likely be held to be statutorily offensive if not for the fact that the disparaging and disrespectful language was not linked to race, gender or sexual orientation but was descriptive of mental illness and the people who experience it. However, if it happened that the problems identified in the earlier chapters were rectified, there is a further compounding problem. This problem may explain what appears to be the specious and biased reasoning of courts in support and defence of what are, at times, seen to be indefensible decisions: sanism.

¹ Karl Popper, 'Science : Conjectures and Refutations', Ch. 1, Section VII, <http://worthylab.tamu.edu/courses_files/popper_conjecturesandrefutations.pdf> 26

² Scott Burris, 'Stigma and the Law' (2006) 367 *The Lancet* 529.

Chapter Five examines Michael Perlin's dualistic theories of sanism and pretextuality which, he claims, riddle social policy, are written into law, and influence judicial decision-making.³ The normal operating framework of the legal system is widely regarded as a system that provides legal parties with a level playing field: a neutral environment in which impartial decision-makers with good statutory interpretation techniques arrive at fair and just outcomes. Perlin argues that this environment is not neutral when a party has a mental illness because the system is inherently biased against mental illness. A person who carries a medical label of 'mentally ill' will acquire the prejudicial legal label of erratic, unpredictable, disorganised, without credibility and potentially, and quite probably, dangerous⁴ immediately they enter the legal system.⁵ Dangerousness is a component of stigma and central to prejudice.⁶ These ascribed attributes of unacceptable difference, Perlin argues, fuel the law's adverse presumptory beliefs and pretextual practices which he describes as 'harmful, irrational prejudice, founded in myths, stereotypes, superstitions, and de-individualization',⁷ and the corruption of the court's processes - pretextuality.⁸

Sanism's interlinked theory, pretextuality, which is the court's practice of employing artifices to help ensure that the morally right, if not in fact, the legally correct decision is reached according to Perlin. In uncomfortable areas of law, courts commonly seek refuge in expressing common sense morality to utilise heuristic devices,⁹ and they are willing to rely on suspect evidence to justify decision-making that ignores rights. Perlin argues that pretextuality is poisonous because 'it infects all participants in the judicial system, breeds cynicism and disrespect for the law, demeans participants, and reinforces shoddy lawyering, blasé judging, and, at times, perjurious and/or corrupt testifying'.¹⁰ Rather than applying the law to ensure parties experiencing mental illness achieve fair and equitable legal

³ Michael L Perlin and Deborah A Dorfman, 'Sanism, social science, and the development of mental disability law jurisprudence' (2006) 11 *Behavioral Sciences & the Law* 47.

⁴ Michael L Perlin, *The Hidden Prejudice: Mental Disability on Trial* (American Psychological Association, 2000).

⁵ Ibid.

⁶ Matthew Large and Christopher J Ryan, 'Sanism, stigma and the belief in dangerousness' (2012) 46 *Australian & New Zealand Journal of Psychiatry* 1099.

⁷ Michael L Perlin, "'Half-Wracked Prejudice Leaped Forth': Sanism, Pretextuality, and Why and How Mental Disability Law Developed as it Did" (1999) 10 *Journal of Contemporary Legal Issues* 3, 5.

⁸ Michael L Perlin, "'And My Best Friend, My Doctor/Won't Even Say What It Is I've Got': The Role and Significance of Counsel in Right to Refuse Treatment Cases" (2005) 42 *San Diego Law Review* 735.

⁹ Perlin, above n 4, 136.

¹⁰ Michael L Perlin, "'Through the Wild Cathedral Evening': Barriers, Attitudes, Participatory Democracy" (2008) 13 *Texas Journal On Civil Liberties and Civil Rights* 413, 417.

outcomes, courts implicitly, or explicitly, will accept false or misleading testimony and engage in biased, superficial or dishonest decision-making to achieve the desired social results that have value to the decision-maker.¹¹ This claim is specifically discussed in Chapter Six with regard to conflicted family law parenting matters.

The theories of sanism and pretextuality are yet to be generally accepted by mainstream lawyers and, as was shown in Chapter Four, when lawyers do acknowledge the concept, they can misunderstand it and/or confuse it with the ideology of political correctness. A suggested reason for why sanism and pretextuality have not been more broadly accepted is that the theories are confrontationalist, portraying the majority of legal actors in a negative light by labelling them as prejudicial and dishonest. It is difficult enough for a lay person to accept that they might be prejudiced and dishonest when told, because everyone has the illusion of their own objectivity.¹² But while legal actors have a tendency to see bias in others, it is often difficult for them to identify their own biases.¹³ This appears to be particularly so for judges who work under community and personal expectations that they are free from preconceptions and bias, and that they will give function to ethical principles of neutrality, fairness, equality, justice and objectivity. While there is some academic scepticism surrounding the ‘false claims’ of the court’s objectivity and neutrality,¹⁴ that discussion is a long way distant from Perlin’s heretical claims of prejudice and dishonesty.

A careful consideration of the weight of the literature bringing the powerful concepts of sanism and pretextuality to academic attention shows that it has been published mainly by Perlin himself, although over the past three decades a small but keen commentary support base has grown. Sanism has largely been uncritically accepted, with its minimal testing focused on the attitudes of jurors in death penalty

¹¹ Perlin, above n, xix.

¹² Tom Pyszczynski and Geoff Greenberg, ‘Toward an integration of cognitive and motivational perspectives on social inference: A biased hypothesis-testing model’, 297. In Leonard Berkowitz, (ed), *Advances in experimental social psychology*, Vol. 20, (Academic Press, 1987)

¹³ Mary R Rose, Christopher Ellison and Shari Seidman Diamond, ‘Preferences for Juries Over Judges Across Racial and Ethnic Groups’ (2008) 89 *Social Science Quarterly* 372.

See also Emily Pronin, Thomas Gilovich and Lee Ross, ‘Objectivity in the Eye of the Beholder: Divergent Perceptions of Bias in Self Versus Others’ (2004) 3 *Psychological Review* 781.

¹⁴ Carrie Menkel-Meadow, ‘The Trouble with the Adversary System in a Postmodern, Multicultural World’ (1996) 38 *William and Mary Law Review* 5.

cases.¹⁵ Chapter Eight endeavour to test sanism by surveying the attitudes of law students upon their entry into law school and compare them with their attitudes upon exiting law school. It will also assess the influence that participating in the clinical training and representation program founded on principles of therapeutic jurisprudence that is discussed in Chapter Seven had on improving students' attitudes.

While stigma stems from intolerance and the lack of compassion for difference, prejudice is 'an unfavourable opinion or feeling formed beforehand without knowledge, thought, or reason'.¹⁶ This distinction is an important one but despite the different theoretical health, science and legal perspectives and definitions of stigma and prejudice, colloquially, 'stigma' is commonly used to refer to the public's negative and prejudicial attitudes.¹⁷ Unlike stigmatising attitudes, prejudicial attitudes are not necessarily the products of small, foolish minds.¹⁸ This chapter will show that legislators, judges, lawyers and psychiatric expert witnesses are just as susceptible to the cognitive errors of prejudice as is everyone else. It will examine the law's reliance on the medical model, and the importance that it gives to the psychiatric expert. Courts readily turn to psychiatric opinion to both guide and justify their decision-making. However, the reality of the relationship is not the media generated perception of a performance of two competing institutions meeting at the junction where the person's rights are at judicial issue, but an interdependent interplay between law and psychiatry within a 'treatment and control' legal system that has as its intention and function, the taking 'care of' those residual cases that society views as problematic.'¹⁹

¹⁵ The prejudice of jurors in death penalty cases has been the subject of extensive research and discussion. Perlin raised the issue in 'The sanist lives of jurors in death penalty cases: The puzzling role of "Migrating" mental disability' (1994) 8 *Notre Dame Journal of Law, Ethics & Public Policy* 239. Twenty years later, he again deals with the issue in his newest book; Michael L Perlin, *Mental Disability and the Death Penalty: The Shame of the States* (Rowman & Littlefield Publishers, 2013). See also Bruce J Winick, 'The Supreme Court's Evolving Death Penalty Jurisprudence: Severe Mental Illness as the Next Frontier' (2009) 50 *Boston College Law Review* 785. See also Kevin M O'Neil, Marc W Patry and Steven D Penrod, 'Exploring the Effects of Attitudes Toward the Death Penalty on Capital Sentencing Verdicts' (2004) 10 *Psychology, Public Policy, and Law* 443. See also Christopher Slobogin, 'Mental Illness and the Death Penalty' (2000) 24 *Mental & Physical Disability Law Report* 667. See also Stephen P Garvey, 'The Emotional Economy of Capital Sentencing' (2000) 75 *New York University Law Review* 26.

¹⁶ *Macquarie Dictionary*, (Macquarie University Press, 5th edition, 2009).

¹⁷ Heather Stuart, Julio Arboleda-Florez and Norman Sartorius, *Paradigms Lost* (Oxford University Press, 2012).

¹⁸ Large and Ryan, above n 6.

¹⁹ Bernadette Dallaire *et al.*, 'Civil commitment due to mental illness and dangerousness: the union of law and psychiatry within a treatment-control system' (2000) 22 *Sociology of Health & Illness* 679, 679.

Chapter Five is important to this thesis because first, it brings Perlin's 'hidden prejudice' into public discussion. Sanism is different from other prejudices because, according to Perlin, it is a self-perpetuating, socially acceptable prejudice, inherently bound up in the public's thoughts, fears, language, and humour. It is largely invisible, and unrecognised by those who would otherwise be expected to champion its eradication: the courts. The court's use of stereotypical presumptions, its balancing of moral values and principles and its use of heuristics result in biased, paternalistically beneficent, more restrictive, and less just outcomes for people experiencing mental illness. If sanism is to be eradicated from the legal landscape so that people who experience a mental illness can be integrated with equal standing into a more equitable, just and fair society, the first step must be to recognise and acknowledge sanism and its perniciousness.

Secondly, Perlin's theories help to explain the findings in regard to decisions made in the recent Australian family law parenting order cases examined in Chapter Six. The results also help provide empirical support for Perlin's sanist theory. Thirdly, the empirical study in Chapter Eight rests on the proposition that sanism exists. The research questions try to answer to what extent, and which variables including maturity, legal education, clinical legal training and contact can improve the attitudes of law students toward mental illness and people who experience mental illness.

2. DEFINING 'MENTAL ILLNESS' PREJUDICE

The ubiquity of stigma and the lack of language to describe its discourse have served to delay its passing...there is no word for prejudice against mental illness.²⁰

The first attempts to create a definitive word to describe the prejudice toward people experiencing mental illness arose out of the beginnings of the ex-patient movement in 1970 when the spread of the newly forming mental health community organisations realised the existence of an array of negative assumptions

²⁰ Peter Byrne, 'Challenging healthcare discrimination' (2010) 16 *Advances in Psychiatric Treatment* 60, 67. Dr Byrne is the current Director of Public Education for the Royal College of Psychiatrists, United Kingdom.

attached to mental health patients.²¹ Judi Chamberlain found that they were assumed to be incompetent, incapable, in constant need of supervision and assistance, unpredictable, irrational, and likely to be violent by people who did not have a mental illness experience.²² Surprisingly, these same assumptions were also found to be held by people who had experience of mental illness²³ and who, over time, had internalised the public's negative attitudes.²⁴

Chamberlin, one of the early leaders of the American ex-patient movement, coined the term 'mentalism' to describe these assumptory prejudices directed toward people who had received psychiatric treatment.²⁵ She considered mentalism to be 'endemic, pervasive and institutionalised'²⁶ and just as with any other 'ism' such as racism, sexism and ageism, it was characterised by the complex social inequities of power that resulted in the ubiquitous mistreatment of people labelled 'mentally ill'.²⁷ Mentalism separated people into 'us' and 'them' groups. The members of the power-up group were assumed to be 'normal', i.e. healthy, reliable and capable while the 'abnormal' members of the power-down group were assumed to be crazy, erratic, sick, disabled and violent.²⁸ Mentalism was typically about being a powerless sick person who is expected to be compliant with the treatment orders mandated by the powerful healthy group.²⁹ The search for a single descriptive label for the particular prejudice associated with mental illness resulted in other terms being tendered such as 'sane chauvinism'³⁰ and 'psychophobia'³¹ with

²¹ Among the earliest ex-patient groups were the Insane Liberation Front founded in 1970 and the Mental Patients' Liberation project and the Mental Patient's Liberation Front which were both founded in 1971.

²² Judi Chamberlin, *On Our Own: Patient-Controlled Alternatives to the Mental Health System* (McGraw-Hill, 1978).

²³ Ibid.

²⁴ Betty Blaska, 'First Person Account: What It Is Like to Be Treated Like a CMI' (1991) 17 *Schizophrenia Bulletin* 173.

²⁵ Chamberlin, above n 22.

²⁶ Denise Tanner, 'Crossing bridges over troubled waters?: Working with children of parents experiencing mental distress (2000) 19 *Social Work Education: The International Journal* 287, 295.

²⁷ Coni Kalinowski and Pat Risser, 'Identifying and Overcoming Mentalism' (Research Paper, InforMed Health Publishing & Training, July 2000)

<http://counterpsych.com/uploads/23542/uploadedDocuments/Mentalism_07_00.pdf>.

See also Marit Borg, Bengt Karlsson and Hesook S Kim, 'User involvement in community mental health services – principles and practices' (2009) 16 *Journal of Psychiatric and Mental Health Nursing* 285.

²⁸ Kalinowski and Risser, above n 27.

²⁹ Marit Borg, Bengt Karlsson and Hesook S Kim, 'User involvement in community mental health services – principles and practices' (2009) 16 *Journal of Psychiatric and Mental Health Nursing* 285, 289.

³⁰ Judi Chamberlin, 'The Ex-Patients' Movement: Where We've Been and Where We're Going' (1990) 11 *The Journal of Mind and Behavior* 323.

³¹ Peter Byrne, 'Stigma of mental illness and ways of diminishing it' (2000) 6 *Advances in Psychiatric Treatment* 65, 67.

‘psychophobic’ suggested as the descriptive label for a person who held prejudicial attitudes and incorrect exaggeration.³²

Pizzuro stated Perlin ‘has coined two terms that are quickly becoming universally accepted within the world of Mental Disability Law’.³³ Perlin himself credits the American lawyer, Morton Birnbaum, as the person who, in his article *The Right to Treatment*,³⁴ first coined the term ‘sanism’.³⁵ Birnbaum’s concept of sanism is discussed in 7.0. Although acceptance of the term ‘sanism’ may still be some distance from being universal, there is a burgeoning preference, particularly amongst mental health consumers, for the term to be used to describe the prejudice associated with mental illness.³⁶

3. SANISM OR STIGMA?

Prejudicial beliefs and discriminatory behaviours are components of both stigma and sanism, which, although conceptually different,³⁷ are seemingly bound together in symbiotic perpetuance ‘[b]ecause sanism produces stigma and stigma leads to sanism’.³⁸ Stigma is the overarching, prevalent and generally ignored oppression that is built on a framework of sanist beliefs, attitudes and practices.³⁹ Although there are many definitions of stigma, the classic formulation is Goffman’s ‘deeply discrediting attribute’ intimately linked to the reproduction of social difference⁴⁰ which was discussed at length in Chapter Three. Goffman’s theory is based on a person differing in some characteristic from the cultural or social norms and it is this unique characteristic of difference which distinguishes the stigmatised person as someone deserving of disapproval. The association of negative qualities such as

³² Ibid.

³³ Salvatore Pizzuro, ‘The implications of the Atkins Concept on the Lives of People with Disabilities in Criminal and Civil Courts’ (Research Paper, 2009) 3 <<http://s395229360.onlinehome.us/Research/Legal/PizzuroOnAtkins%282009%29.pdf>>.

³⁴ Morton Birnbaum, ‘The Right to Treatment’ (1960) 46 *American Bar Association Journal* 499.

³⁵ Perlin, above n 4, 22.

³⁶ Robert Menzies, Brenda A LeFrançois and Geoffrey Reaume (eds), *Mad Matters: A Critical Reader in Canadian Mad Studies* (Canadian Scholars’ Press Inc., 2013).

³⁷ Jennifer Piel, ‘Mental Disability Law, Evidence, and Testimony: A Comprehensive Reference Manual for Lawyers, Judges, and Mental Disability Professionals’ (2010) 38 *Journal of American Academy of Psychiatry and the Law* 619.

³⁸ John W Parry, *Criminal Mental Health and Disability Law, Evidence and Testimony: A Comprehensive Reference Manual for Lawyers, Judges and Criminal Justice Professionals* (American Bar Association, 2009) 48.

³⁹ Jennifer M Poole *et al.*, ‘Sanism, ‘Mental Health’, and Social Work/Education: A Review and Call to Action’ (2012) 1 *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice* 20.

⁴⁰ Erving Goffman, *Stigma: notes on the management of spoiled identity* (Prentice-Hall, 1963).

dangerousness, unpredictability, moral weakness and helplessness with having a mental illness creates the stigma that feeds upon, strengthens and reproduces existing social inequalities.

Thornicroft presents stigma as an overarching term containing three elements: problems of knowledge (ignorance), problems of attitudes (prejudice), and problems of behaviour (discrimination).⁴¹ He suggests that the term binds together stereotypes, ignorance and negative attitudes and behaviours to the disadvantage of a stigmatised group. Although the term 'prejudice' is commonly used in reference to marginalised groups experiencing disadvantage, for example ethnic minorities, it is rarely used in regard to people with mental illness.⁴² Rejection, he argues, usually requires a combination of negative thoughts and negative emotions such as anxiety, anger, resentment, hostility, distaste or disgust. He notes that, interestingly, apart from describing a fear of violence, there is little published about emotional reactions to people who experience mental illness.⁴³ Angermeyer also suggests that the public's emotional reactions are relatively under-researched and that more research could help better understand the complexities of mental illness stigma.⁴⁴

Phelan examined the intersection of the conceptual models of stigma and prejudice and determined that the models had much in common and that it was simply a matter of emphasis and focus that accounted for most of the differences between the two models.⁴⁵ He suggested that stigma and prejudice have three functions: exploitation and domination (keeping people down), disease avoidance (keeping people away) and norm enforcement (keeping people in).⁴⁶ Corrigan separated the concept into two categories, public stigma and self stigma which were then broken down into three social cognitive components; stereotypes (efficient social belief or knowledge structure), prejudice (emotion-based endorsement or evaluation of stereotype) and discrimination (behavioural result of prejudice).⁴⁷

⁴¹ Graham Thornicroft *et al.*, 'Stigma: ignorance, prejudice or discrimination?' (2007) 190 *British Journal of Psychiatry* 192.

⁴² *Ibid.*

⁴³ *Ibid.*

⁴⁴ Matthias C Angermeyer, Andreas Holzinger and Herbert Matschinger, 'Emotional reactions to people with mental illness' (2010) 19 *Epidemiologia e Psichiatria Sociale* 26.

⁴⁵ Jo C Phelan, Bruce G Link and John F Dovidio, 'Stigma and prejudice: one animal or two?' (2008) 67 *Social Science and Medicine* 358.

⁴⁶ *Ibid.*

⁴⁷ Patrick W Corrigan and Amy C Watson, 'Understanding the impact of stigma on people with mental illness' (2002) 1 *World Psychiatry* 16.

Stigma is about society's intolerance and lack of acceptance and compassion for people who are different.⁴⁸ Prejudice is an unfavourable opinion or feeling about a person that is formed beforehand without knowledge, thought or reason.⁴⁹ The general belief that the holding of irrational, preconceived ideas and adverse judgments regarding normality and difference by the culturally and socially normal members of society is a predictor for the performance of prejudicial actions is not supported by empirical evidence. Prejudice is considered only rare, as a valid predictor of discriminatory behaviour.⁵⁰

Sanism is 'a disease of attitudes.'⁵¹ It is:

an irrational prejudice of the same quality and character as other irrational prejudices that cause and are reflected in prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry that permeates all aspects of mental disability law and affects all participants in the mental disability law system: litigants, fact finders, counsel, and expert and lay witnesses.⁵²

Perlin's focus on the legal system might suggest a narrow interpretation of sanism as relevant to the administration of law and the delivery of legal services, but taking this narrow view would be ill advised as Perlin's concept is applicable to all aspects of structural stigma, prejudice and discrimination and should not be confined to only discussions of the unfairness and inadequacies of the legal system.

The concept of sanism is preferable to that of stigma because the elements of sanism include intolerance, lack of acceptance and compassion, prejudice, use of stereotypes and myths, ignorance and the unfair and inequitable treatment of people experiencing a mental illness. While sanism shares the dominant and overarching principle shared by all other 'isms' - an ideological rationalization or justification for stigmatizing and marginalizing the other - it is set apart from other 'ism'

⁴⁸ Large and Ryan, above n 6.

⁴⁹ *Macquarie Dictionary*, (Macquarie University Press, 5th edition, 2009).

⁵⁰ Heidi Shutz and Bernd Six, 'How Strong is the Relationship Between Prejudice and Discrimination? A Meta-Analytic Answer' (1996) 20 *International Journal of Intercultural Relations* 441.

⁵¹ Michael L Perlin, 'They're An Illusion to Me Now': Forensic Ethics, Sanism and Pretextuality' (Research Paper Series No 07/08-27, New York Law School Legal Studies, 2008) <<http://ssrn.com/abstract=1130923>>.

⁵² Michael L Perlin, "'His Brain Has Been Mismanaged with Great Skill': How Will Jurors Respond to Neuroimaging Testimony in Insanity Defense Cases?' (2009) 42 *Akron Law Review* 885.

discussions because sanist theory brings with it unique, additional critical elements: sanism is largely invisible, socially acceptable, and frequently practised.⁵³

4. LITERATURE ON SANISM

I have begun to write regularly, relentlessly, I might even say about sanism and pretextuality, so as to seek to expose their pernicious power, the ways in which two factors infect judicial decisions, legislative enactments, administrative directives, jury behavior, and public attitudes.⁵⁴

The body of literature on sanism is built mainly on Perlin's own prolific writings over the past 30 years, and his collaborations with other authors. Academic discussion and expressions of support have come mainly from Perlin's circle of colleagues at the New York School of Law, and the promoters of a therapeutic jurisprudential approach to mental health law. In 2002/3 there was a small flurry of articles written by the New York Law School academic cohort which included Champine's article, *A Sanist Will*.⁵⁵ Champine suggested that sanism and pretextuality provided a novel framework for analysing the problem of discrimination that she claimed ran rampant through the law of wills.⁵⁶ On a parallel path, Ellis, also writing on testamentary law, narrowed her discussion of sanism and pretextuality to the civil probate hearing⁵⁷ while Claire B. Steinberger produced *Therapeutic Jurisprudence: The "Sanist" Factor – An Interdisciplinary Approach*, that offered a detailed, though short, positive analysis of Perlin and Champine's theories.⁵⁸

Champine again undertook collaboration with Perlin in their joint 2008 publication, *Competence in the Law*.⁵⁹ Another co-author of the book was clinical psychologist, Mary Connell, who wrote as her dedication in the book, '[f]or all the people whose

⁵³ Richard Ingram, Sanism in Theory and Practice (Conference paper, 2nd Annual Critical Inquiries Workshop, 2011) <http://www.socialinequities.ca/wordpress/wp-content/uploads/2011/07/Ingram.Sanism-in-Theory-and-Practice.CI_2011.pdf>.

⁵⁴ Perlin, above n 7, 26.

⁵⁵ Pamela R Champine, 'A Sanist Will' (2002) 46 *New York School of Law Review* 547.

⁵⁶ Ibid 547.

⁵⁷ Heather S Ellis, 'Dealing With Mental Disability in Trust & Estate Law Practice: "Strengthen the Things that Remain." The Sanist Will' (2003) 46 *New York Law School Journal of International & Comparative Law* 565.

⁵⁸ Claire B Steinberger, 'Therapeutic Jurisprudence: The Sanist Factor-An Interdisciplinary Approach' (2002) 46 *New York Law School Law Review* 573. Claire was a J.D. candidate at the New York Law School in 2003.

⁵⁹ Michael L Perlin et al., *Competence in the Law: From Legal Theory to Clinical Application* (John Wiley & Sons, 2008).

lives have been affected by Professor Perlin's contributions'.⁶⁰ Perlin is an inspiring influence in mental health commentary. However, there has been scant scientific critique of sanism and pretextuality although the experiential realities of legal practice and un-blinkered academic observation have ensured that support continues to grow. Winick, when writing about the 'paternalistic' or 'best interest' advocacy approach that some lawyers within the adversarial system adopt when representing clients experiencing a mental illness commented that, '[t]o some extent, this paternalistic role represents what Perlin has called sanism and pretextuality'.⁶¹

In the preface to *Involuntary Detention and Therapeutic Jurisprudence*, Perlin states that it was personally heartening 'to see how many of the chapters – again mostly without a specific mention ... confirmed my own theoretical perspective on all of mental disability law: that it is sanist and pretextual'.⁶² With reference to the editors' short discussion of sanism and pretextuality in their introductory chapter, he stated that they had concluded that the principles 'place at risk the legitimacy of the [entire mental disability law] decision-making process'.⁶³ Perhaps a more accurate representation is that the editors discussed what 'Perlin has asserted'⁶⁴ by the inclusion of lengthy quotes drawn from Perlin's many books and articles, paraphrasing Perlin's own conclusions.

The editors did remark on Perlin's conviction that sanism and pretextuality were the 'corrosive prejudice' at the root of mental health law, and that pretextuality was a poisonous, infectious, disrespecting, and demeaning reinforcement of disinterested judging, bad lawyering and at times, corrupt and perjurious testimony. Similarly to Winick, their comment was that '[u]ltimately, it is the reassertion of paternalism'.⁶⁵ They suggest that deconstruction of concepts both familiar and prevalent in mental health law such as dangerousness, lack of insight, lack of capacity, non-compliance, need for treatment and best interests can be confronting because it can reveal the 'existence of unacceptable ideologies such as paternalism under covert guise'.⁶⁶

⁶⁰ Ibid v.

⁶¹ Bruce Winick, 'TJ and the Civil commitment Hearing' (1999) 10 *The Journal of Contemporary Legal Issues* 37, 41.

⁶² Kate Diesfeld and Ian R Freckleton (eds), *Involuntary Detention and Therapeutic Jurisprudence* (Ashgate Publishing Limited, 2003) xxxvi.

⁶³ Ibid.

⁶⁴ Ibid 7.

⁶⁵ Ibid.

⁶⁶ Ibid 14-15.

This raises the question as to whether sanism may be a transposing term for paternalism in the minds of some commentators or whether it is a separate concept that either precurses paternalism, or runs parallel to it.

Although ‘paternalism’ lacks a precise definition, it is regarded as the restriction of a person’s self-regarding conduct primarily for their own good.⁶⁷ At the core of all paternalism definitions is the notion that for A’s action to be paternalistic with respect to B, it must promote a utilitarian benefit, or prevent a moral harm to B.⁶⁸ Though widely employed by writers of academic legal literature, judicial opinions, and legislative reports, paternalism as a jurisprudential concept is controversial⁶⁹ because, while its ends are benevolent, its means are usually coercive.⁷⁰ ‘Wise and benevolent paternalism’⁷¹ is sanist behaviour.⁷²

Mention of sanist theory can come with a disclaimer such as sanism is ‘not as professionally acknowledged, researched, or commented upon’⁷³ as other isms such as racism and ageism. The exception is the ‘many thoughtful and well reasoned articles by Professor Michael Perlin’.⁷⁴ Perlin himself acknowledges that much of what he believes and writes is anecdotal and observational, and lacking a scientific basis⁷⁵ and yet, despite the lack of theoretical discourse or benefit of scientific research, sanism has begun to gain acceptance amongst some commentators. As recently as 2012, Large concluded that ‘Perlin believes that our prejudicial attitudes about the mentally ill have seen sanist provisions riddle our law and social policy’.⁷⁶ Large argued that just as people have within themselves a propensity to

⁶⁷ Thaddeus Mason Pope, ‘Counting The Dragon's Teeth And Claws: The Definition Of Hard Paternalism’ (2004) 20 *Georgia State University Law Review* 659.

⁶⁸ David L Shapiro, ‘Courts, Legislatures, and Paternalism’ (1988) 74 *Virginia Law Review* 519.

⁶⁹ Gregory Mitchel, ‘Libertarian Paternalism Is An Oxymoron’ (2005) 99 *Northwestern University Law Review* 1245.

⁷⁰ Peter Suber, ‘Paternalism’ in Christopher B Gray (ed), *Philosophy of Law: An Encyclopedia* (Garland Publishing, 1999) 632. See also Donald Vandevier, *Paternalistic Intervention: The Moral Bounds on Benevolence* (Princeton University Press, 1986). Michael Weiss and Cathy Young, ‘Feminist Jurisprudence: Equal Rights or Neo-Paternalism?’ (Policy Analysis No 256, Cato Institute, 19 June 1996)

<<http://www.cato.org/publications/policy-analysis/feminist-jurisprudence-equal-rights-or-neopaternalism>>.

⁷¹ Chodoff, Paul, ‘Involuntary hospitalization of the mentally ill as a moral issue’ (1984) 141 *The American Journal of Psychiatry* 384.

⁷² Perlin, above n 51.

⁷³ Keri K Gould, ‘“Madness in the Streets” Rides the Waves of Sanism’ (1992) 9 *New York Law School Journal of Human Rights* 567, 569.

⁷⁴ *Ibid*, n 8.

⁷⁵ Michael L Perlin, ‘“You Have Discussed Lepers And Crooks”: Sanism In Clinical Teaching’ (2003) 9 *Clinical Law Review* 683.

⁷⁶ Large and Ryan, above n 6, 1101.

sexism, ageism and racism, prejudices which they must constantly tackle, they now must, just as fiercely, ‘guard against and combat sanism’.⁷⁷

5. AN AMERICAN TRAGEDY: SANISM IN SOCIETY⁷⁸

Perlin credits the person who coined the term ‘sanism’⁷⁹ as the American physician and lawyer Morton Birnbaum, a person who ‘fancied himself a Don Quixote tilting at windmills’.⁸⁰ In what was one of the earliest issues in the newly emerging field of bioethics, Birnbaum, in his 1960 seminal journal article, *The Right to Treatment*,⁸¹ presented the novel proposition that institutionalised ‘mentally ill’ patients had a right to receive adequate medical treatment. This claim of a ‘right to treatment’ provided the impetus for the monumental changes that occurred in mental health care over the next five decades. It continues to influence legal and legislative thinking about the appropriate standard of care to be applied to people experiencing a mental illness, no matter what environment the care is provided in: hospital, prison or in the community. Birnbaum’s revolutionary concept laid the foundation for the rich discourse of legal commentators and libertarian advocates who would go on to argue the existence of other rights such as the right to informed consent, the least restrictive option, and the right to refuse treatment.

During the 1960s, the American courts and concerned commentators began focusing their attention on the adequacy of the treatment provided to people incarcerated for the purposes of treatment or rehabilitation, arguing that it was the right of prisoners, alcoholics⁸², drug addicts⁸³, juveniles⁸⁴ and homosexuals⁸⁵ to receive adequate care and treatment. It was a duty of the government to provide proper mental health care and treatment to incarcerated patients and compelled

⁷⁷ Ibid 1103.

⁷⁸ This is the heading Birnbaum uses when discussing his concept of sanism. Morton Birnbaum, ‘The Right to Treatment: Some Comments on Its Development,’ in Frank J. Ayd Jr. (ed), *Medical, Moral, and Legal Issues in Mental Health Care* (Williams & Wilkins, 1974).

⁷⁹ Perlin, above n 4, 22.

⁸⁰ Rebecca Birnbaum, ‘My Father’s Advocacy for a Right to Treatment’ (2010) 38 *Journal of the American Academy of Psychiatry and Law* 115, 116.

⁸¹ Birnbaum, above n 34.

⁸² Peter Barton Hutt and Richard A Merrill, ‘Criminal Responsibility and the Right to Treatment for Intoxication and Alcoholism’ (1969) 57 *Georgetown Law Journal* 835.

⁸³ *Blunt v. Narcotic Addiction Control Commission*, 295 N.Y.S.2d 276 (Sup.Ct) 296 N.Y.S.2d 533 (App. Div. 1968). See also Paul Gewirtz, ‘Notes and Comments, Methadone Maintenance for Heroin Addicts’ 1969) 78 *The Yale Law Journal* 1175.

⁸⁴ *In re Harris*, 2 Crim. L. Rep. 2412 (Cook County, Ill., Cir. Ct., Juv. Div. 1967); *Kent v. United States*, 401 F.2d 408 (D.C. Cir. 1968).

⁸⁵ *Ceschini v. Warden*, 30 App. Div. 2d 649 291 N.Y.S.2d 200 (1968) (per curiam).

community patients⁸⁶ in line with the principle of reciprocity and the ideologies of entitlement. Birnbaum argued that the provision of adequate treatment was more than government largesse sympathetically extended to disadvantaged indigents but it was a moral and legal obligation constitutionally imposed on the state.⁸⁷ It was *quid pro quo* for the deprivation of liberty that accompanies civil commitment. This treatment-in-exchange-for-liberty argument underpinned the dismantling of the warehousing public mental hospital system.⁸⁸

Twenty years later, Gostin would refer to the ‘ideology of entitlement’ as the premise that access to health and social services should not be based upon charitable or professional discretion, but upon enforceable rights.⁸⁹ Eastman suggested that the principle of reciprocity balances the state's right to deprive a psychiatric patient of his or her rights against the state's duty to allocate the resources required for treatment.⁹⁰ In 1999, the United Kingdom government’s Expert Committee for the Review of the Mental Health Act 1983 stated that:

the provision of mental health care, unlike virtually all other forms of health care, may have to be delivered by the use of compulsory powers. In these circumstances we are persuaded that the principle of reciprocity imposes special obligations: when society compels an individual to accept mental health care services those services must be available and of an appropriate quality.⁹¹

5.1 Stephens and Donaldson

In May of 1960, two involuntarily detained patients contacted Birnbaum separately after reading an article published in the New York Times supporting his ‘right to treatment’ proposition.⁹² The first, Edward Stephens, had been involuntarily committed for 30 years without adequate medical treatment in appalling, dangerous

⁸⁶ Honora A Kaplan, ‘Institutions and Community Mental Health: The Paradox in *Wyatt v. Stickney*’ (1973) 9 *Community Mental Health Journal* 34.

⁸⁷ Morton Birnbaum, ‘The Right to Treatment’ (1960) 46 *American Bar Association Journal* 499, 499.

⁸⁸ Ralph Slovenko, ‘The past and present of the right to treatment: a slogan gone astray’ (1981) 9 *Journal of Psychiatry and Law* 264.

⁸⁹ Larry O Gostin, ‘Contemporary, Social Historical Perspectives on Mental Health Reform’ (1983) 10 *Journal of Law and Society* 47.

⁹⁰ Nigel Eastman, ‘Mental health law: civil liberties and the principle of reciprocity’ (1994) 308 *British Medical Journal* 43.

⁹¹ Report of the Expert Committee, 1999. iii.

<http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4062614.pdf>.

⁹² George M Grant, ‘Donaldson, Dangerousness, and the Right to Treatment’ (1976) 3 *Hastings Constitutional Law Quarterly* 599.

conditions.⁹³ ⁹⁴ Birnbaum would submit 12 separate ‘inadequate treatment’ claims before state and federal courts, and on three occasions, before the Supreme Court,⁹⁵ but no court would consent to hear Stephen’s case. He was eventually discharged because of a change in administrative policy rather than as a result of legal intervention.⁹⁶ The second patient was Kenneth Donaldson. His case resulted in 14 years of protracted litigation for Birnbaum, culminating in a landmark decision that gave judicial recognition to the right that non-dangerous, institutionally detained patients had a right to adequate treatment.⁹⁷

Birnbaum would become co-counsel in a class action brought by more than 5,000 patients of an Alabama mental hospital in 1971. Lawyers for the plaintiffs in *Wyatt v Stickney*⁹⁸ investigated the facility’s history of incidents which included the case of a boy with profound intellectual disabilities who had a garden hose inserted into his rectum and filled with water which ruptured his spleen and killed him. Another incident concerned a patient restrained in a strait jacket for nine years to prevent him from sucking his hand and fingers.⁹⁹ Birnbaum came to appreciate the true scope of human rejection, rooted deep in the system charged with the care and protection of people experiencing mental illness. It would take 14 years of confronting the prejudices of both the legal and medical systems before Birnbaum eventually coined the term ‘sanism’.¹⁰⁰ According to Birnbaum, sanists are bigots who perpetrate sanism deliberately although he acknowledged that sometimes sanism is unintentional, even though the consequences are the same. He believed that it is the lack of sociological and psychological insight into one’s own prejudicial thinking, feelings and behaviours¹⁰¹ that generates the irrational fear of

⁹³ Donaldson was held with dangerous criminals in Florida State Hospital even though he was not dangerous to himself or others. His ward was understaffed, with only one doctor (who happened to be an obstetrician) for over 1,000 male patients. There were no psychiatrists or counsellors, and the only nurse on site worked in the infirmary.

⁹⁴ An elderly bedridden male patient was sexually assaulted and strangled to death by the lone night attendant in charge of the Stephen’s ward. Sexually assaulting helpless bedridden patients was a long time, regular practice of the attendant.

⁹⁵ Birnbaum, above n 189.

⁹⁶ Grant, above n 201.

⁹⁷ *O’Connor v Donaldson*, 422 U.S. 563 (1975).

⁹⁸ *Wyatt v. Stickney*, 334 F. Supp. 1341, 1343 (M.D. Ala. 1971).

⁹⁹ Lauren Wilson Carr, ‘Wyatt v. Stickney: A Landmark Decision’, *Alabama Disabilities Advocacy Program Newsletter* (online), July 2004 <<http://www.adap.net/Wyatt/landmark.pdf> accessed 14/1/2011>.

¹⁰⁰ Morton Birnbaum, ‘The Right to Treatment: Some Comments on Its Development,’ in Frank J. Ayd Jr. (ed), *Medical, Moral, and Legal Issues in Mental Health Care* (Williams & Wilkins, 1974).

¹⁰¹ *Ibid* 109.

mental illness¹⁰² which permits courts to ignore, or determine prejudicially, the rights of people who experience a mental illness.

Birnbaum offered as a counteracting solution - the realistic recognition of the right to treatment - a concept that, in his opinion, would help deter, and offset society's irrational oppression.¹⁰³ The early critics of the resulting new wave of libertarian laws argued that because it was more difficult to forcibly treat people experiencing serious mental illness, vulnerable people were left 'to die with their rights on' from incidents that included accidents, suicides, neglect and starvation.¹⁰⁴ Forty years later, the catch phrase continues to dominate mental health discussions with Ruth Forrest, Member of the Legislative Council recently warning the Tasmanian Legislative Council Select Committee on Mental Health Legislative Measures that 'It is necessary to ensure that the rights argument does not swing too far to the point where we see people "dying with their rights on"'.¹⁰⁵

But, as is typically the case in the confused commentary of mental health, the negative concept of 'dying with their rights on' can also be presented in a positive context as the successful outcome of the changed laws. In a journal article assessing the impact of recently enacted mental health legislation in Tasmania, the author suggested that the new laws had resulted in people being more accepted, more informed and wiser, and having more control over their care and treatment. The final sentence of the article read 'So mothball those strait jackets because in Tasmania our involuntarily detained mentally ill can now 'die with their rights on'.¹⁰⁶

¹⁰² Birnbaum, above n 209.

¹⁰³ Ibid 140.

¹⁰⁴ The expression 'dying with their rights on' was coined in 1973 by Treffert to describe the consequences of doctors no longer being able to commit certain mentally ill people as though their legal rights are antithetical to life or health rather than supportive of them. Darold A Treffert, 'Dying with Their Rights On' (1973) 130 *American Journal of Psychiatry* 1041.

¹⁰⁵ Ruth Forrest, MLC, Speech to Mental Health Legislative Measures Select Committee - 27 October 2009 <<http://www.ruthforrest.com.au/index.php/parliament/speeches/2009/70-2009-speeches-on-motions/450-mental-health-legislative-measures-select-committee-27-october-2009>>.

¹⁰⁶ Lorette Langford, 'The New Mental Health Act in Tasmania (1996): A Comparative Review with the Former Act (1963): "Can they Now Die with their Rights On?"' (2003) 10 *Psychiatry, Psychology and Law* 140, 143.

6. SOME THINGS LAST LONGER THAN YOU THINK THEY WILL.¹⁰⁷

Perlin informs his readers that it was in the seventies, when as a young public defender reading Birnbaum's article on sanism,¹⁰⁸ he found the theoretical explanation for his witness of the legal system's unfair dealings with people with a mental illness.¹⁰⁹ Sanism offered sense to the charades and subterfuges that he saw perpetrated by judges, lawyers, police and officials in New Jersey's courtrooms. It was this newly gained awareness of the sanist attitudes and pretextual complicities in mental health law that helped set Perlin the practitioner, activist, theorist and academic on the long road of championing the rights of people experiencing mental illness.

Morris alludes to Perlin's own, Birnbaumesque Don Quixote essence when he concludes that:

The windmills that Michael contests are not mere figments of his imagination. They are real and continuing problems. Michael is an irresistible force. But our attitude-our prejudice-toward the mentally disabled may well be an immovable object. How long will Michael continue to speak in a forest, while we hear only "sounds of silence"?¹¹⁰

Perlin argues that sanism is rooted in myth, stereotypes, superstition and de-individualisation, and is sustained and perpetuated through ordinary common sense and heuristic reasoning in an unconscious response to everyday life events, and the legal process.¹¹¹ It is not constrained within the parameters of ignorance and intolerance attributed to lower socioeconomic status¹¹² but travels unnoticed and unrestricted through the corridors of our courts of justice and our schools of legal

¹⁰⁷ Bob Dylan, *Cold Irons Bound*, Columbia Records. Michael Perlin is a lover of all things Dylan and often titles his academic writings with Dylan lyrics.

¹⁰⁸ Birnbaum, above n 209.

¹⁰⁹ Perlin, above n 4, xi.

¹¹⁰ Grant H Morris, 'Pursuing Justice for the Mentally Disabled' (Research Paper, University of San Diego School of Law, Public Law and Legal Theory Research Paper Series, Paper 31 (2005) p.1-32

¹¹¹ Perlin, above n 4, xviii-xix.

¹¹² "There is a strong negative association between measures of intellectual development, such as education and academic achievement, and ethnocentrism and other forms of social intolerance... It is at least conceivable that more educated people are better equipped than others to express socially desirable opinions and that their self-reported levels of tolerance are therefore somewhat inflated. Nevertheless, the relationship between education and tolerance is strong and observed across a number of different methodological paradigms" Jaime L Napier and John T Jost, 'The "Antidemocratic Personality" Revisited: A Cross-National Investigation of Working-Class Authoritarianism (2008) 64 *Journal of Social Issues* 595, 599-600.

learning. This is because sanism pervades public attitudes¹¹³ and the legal system is not immune from its insidious suffusion.¹¹⁴

Judges, lawyers, politicians and legal educators are embedded in the cultural presumptions of mental illness which engulf the societal ‘all’. They possess the same negative attitudes and cultural presumptions, and demonstrate the same biased behaviours borne out of fear, anxiety, and paternalistic beneficence. Sanism is harmful and yet, according to Perlin, it is frequently practised either consciously or unconsciously by individuals who would normally take more open-minded, liberal stances, particularly in their professional lives: people who would decry similar biases or prejudices involving race, gender, ethnicity or sexual orientation.¹¹⁵ One such example occurred during Lawfest 2003,¹¹⁶ an annual Tasmanian event for high school students considering undertaking a university law degree. From an ‘elevated vantage of expertise’,¹¹⁷ community leaders address the students on topical legal issues. During a sentencing workshop, Supreme Court Justice Underwood¹¹⁸ spoke about Tasmania’s only prison; decrying it as awful, humiliating, inhumane, and soul destroying.¹¹⁹ The judge had formed this opinion when visiting the prison regularly as a practising lawyer. He told his impressionable young audience of potential lawyers that, ‘Not only are you locked up, you have to mix with people you wouldn’t spend five minutes with in your ordinary life, psychopaths, schizophrenics, thugs and murderers’.¹²⁰

The newspaper story, with the headline ‘Judge Slams Risdon Prison’ only reported the judge’s condemnation of past prison practices and his optimism that the proposed new correctional facility would be more humane in its service delivery. What went unreported by the media and largely unnoticed by the community in general was the sanist expression of judicial bias in what was an unabashed

¹¹³ Ann K Adler and Otto F Wahl, ‘Children’s Belief about People Labelled Mentally Ill’ (1998) 68 *American Journal of Orthopsychiatry* 321. A considerable body of literature has established that adults hold unfavourable views about people labelled mentally ill and associate negative characteristics with that label.

¹¹⁴ Perlin, above n 4.

¹¹⁵ Michael L Perlin, ‘On “Sanism”’ (1992-1993) 46 *Southern Methodist University Law Review* 373.

¹¹⁶ This is an annual conference organized by the University of Tasmania’s Law Faculty and School of Government. It is attended by approximately 450 high school legal studies students and their teachers

¹¹⁷ Don Chalmers, ‘University of Tasmania’s Dean of Law, Professor Don Chalmers made the statement in a media release dated 31 August, 2009,

<http://www.media.utas.edu.au/__data/assets/pdf_file/0016/12256/Lawfest-FOR-WEB.pdf>.

¹¹⁸ Justice Underwood was appointed Chief Justice of the Supreme Court of Tasmania in 2004 and on 27th April, 2008 he was sworn in as the State of Tasmania’s 27th Governor.

¹¹⁹ The Saturday Mercury Newspaper, August 23, 2003, p.5.

¹²⁰ Ibid.

perpetuation of the discrimination of the mind.¹²¹ By voicing the socially exclusive assumption that people would not choose to spend five minutes of their ordinary lives mixing with ‘schizophrenics’, he not only reaffirmed the stigma attached to more than 1%¹²² of the population, and their families; he gave it credibility. He publically labelled as criminal, the medical diagnoses of schizophrenia and psychopathy/antisocial personality disorder¹²³ while using language that was ‘politically incorrect’, stigmatizing, and fear causing. It is these sanist attitudes that Perlin argues drives the pretextual processes in the legal system.

7. PRETEXTUALITY

Perlin argues that mental health policies and laws are developed and implemented in response to sanist attitudes and myths, and that legal cases are conducted and decided in accordance with his second theory, pretextuality, which he claims poisonously infects all participants in the judicial system, breeds cynicism and disrespect for the law, demeans participants, and reinforces shoddy lawyering, blasé judging, and, at times, perjurious and/or corrupt testifying.¹²⁴ It is judicial engagement in a course of decision-making that is intended to achieve the decision-makers preferred outcome¹²⁵ and judges, jurors and fact finder decision-makers often, consciously, or unconsciously rely on reductionist, prejudice driven stereotypes in their decision-making thereby subordinating the legitimate interests of the person experiencing the mental illness.¹²⁶

For Perlin, pretextuality is the court’s acceptance of the testimonial dishonesty of expert, often conflicted, witnesses who demonstrate a high propensity to purposely distort their evidence in order to achieve their preferred ends.¹²⁷ Pretextuality festers largely unseen in the courtroom where experts openly subvert statutory and case law criteria by frequently giving evidence that is a heuristically biased

¹²¹ People who presently have, or have a past history of mental illness are often denied insurance or have inequitable limits placed on the amount of benefits receivable. Anti-discrimination laws blatantly permit insurers to discriminate against the mentally ill. *Anti-discrimination Act 1998* (Tas) s 44.

¹²² 1% represents number of people having a diagnosis of schizophrenia. The statistic would be 5% if it included people with antisocial disorder.

¹²³ James R P Ogloff, ‘Psychopathy/antisocial personality disorder conundrum’ (2006) 40 *Australian New Zealand Journal of Psychiatry* 519, 519.

¹²⁴ Perlin, above n 7.

¹²⁵ Ibid, xix.

¹²⁶ Michael L Perlin, ‘Executioner’s Face Is Always Well-Hidden: The Role of Counsel and the Courts in Determining Who Dies’ (1997) 41 *New York Law School Law Review* 201.

¹²⁷ Perlin, above n 7.

simplification of thinking¹²⁸, relying on strategies such as the ‘vividness effect’¹²⁹ or attribution theory¹³⁰, or evidence that accords with their own self-referential concepts of morality.¹³¹ ‘Judges’ predispositions to employ the same sorts of heuristics as do expert witnesses further contaminate the process.’¹³² The following sections examine the court’s use of pretexts.

7.1 Pretextuality in the criminal court

Police perjury¹³³ and criminal courts are aware that police evidence is probably untruthful, and intended to mislead the court.¹³⁴ In the O.J. Simpson case¹³⁵ Judge Ito accepted the police claim that police entered Simpson’s residence without probable cause or warrant because they were concerned for his welfare and not because they considered him to be a suspect. The court then ruled that bloodstains and other physical evidence linking Simpson to the crime scene was to be admitted into evidence.¹³⁶ Prior to entry however, police knew that Simpson had beaten his wife on previous occasions, had found what appeared to be blood on his car, and were unable to find him after the murders making him a major suspect.

A major study that examined the behaviour of narcotic officers in response to the exclusionary evidence rule found that nearly all of the officers admitted that police do perjure,¹³⁷ reasoning that the officers ‘know’ that judges are likely to give the ‘wink’ to police perjury in order to admit incriminating evidence.¹³⁸ Police perjury has been called the dirty little secret of the criminal justice system¹³⁹ albeit, a badly kept secret. If the public is unaware of the fact, certainly ‘[j]udges, prosecutors,

¹²⁸ Perlin, above n 7.

¹²⁹ Rosanna E Guadagno, Kelton V Rhoades and Brad J Sagarin, ‘Figural vividness and persuasion: capturing the “elusive” vividness effect’ (2011) 37 *Personality and Social Psychology Bulletin* 626. See also Marybeth Zientek, ‘*Riggins v. Nevada*: Medicated Defendants and Courtroom Demeanor from the Jury’s Perspective’ (1993) 30 *American Criminal Law Review* 215. See also Jolita Kisielius and Brian Sternthal, ‘Detecting and Explaining Vividness Effects in Attitudinal Judgments’ (1984) 21 *Journal of Marketing Research* 54.

¹³⁰ Daniel J Luchins *et al.*, ‘Lawyers’ Attitudes Toward Involuntary Treatment’ (2006) 34 *Journal of the American Academy of Psychiatry and Law* 492. See also Liza H Gold, *Sexual Harassment: Psychiatric Assessment In Employment Litigation* (American Psychiatric Publishing Inc., 2004).

¹³¹ Perlin, above n 7.

¹³² *Ibid* 18.

¹³³ Christopher Slobogin, ‘Testilying: Police Perjury And What To Do About It’ (1996) 67 *University of Colorado Law Review* 1037.

¹³⁴ *R. v. S. (R.D.)* [1997] 3 S.C.R. 484, n.4

¹³⁵ *People Of The State Of California Plaintiffs, vs. Orenthal James Simpson*, CASE NO. BA 09721, 1995.

¹³⁶ Kenneth B. Noble, *Ruling Aids Prosecution of Simpson*, *New York Times*, Sept. 20, 1994.

<<http://www.nytimes.com/1994/09/20/us/ruling-aids-prosecution-of-simpson.html>>

¹³⁷ Myron W Orfield, ‘The Exclusionary Rule and Deterrence: An Empirical Study of Chicago Narcotics Officers’ (1987) 54 *University of Chicago Law Review* 1016.

¹³⁸ Morgan Cloud, ‘The Dirty Little Secret’ (1994) 43 *Emory Law Journal* 1311.

¹³⁹ *Ibid*.

defense lawyers, and repeat offenders all know that police officers lie under oath'.¹⁴⁰ In a study of 30 major British cases in which the convictions had been quashed on appeal from 1989 to 2005, it was revealed that evidence of serious police impropriety including perjury or other professional malpractice occurred in a third of the cases investigated.¹⁴¹

A rare examination of judicial insouciance toward police misconduct is Orfield's 1992 study of the Chicago criminal court system¹⁴² that found that with regard to judicial behaviour associated with the exclusion of evidence, 77% of the judges surveyed believed that police will, at times, fabricate case reports and affidavits to obtain a search warrant, and 91% believed that police do commit perjury, which as a practice is tolerated, even encouraged, by prosecutors and police superiors.¹⁴³ On the other hand, judges were widely thought to purposefully ignore the law to prevent evidence from being suppressed, and knowingly accept police perjury as truthful, particularly if the judge believed it would lead to an unjust outcome if they did otherwise.¹⁴⁴ Eighty six percent of police officers surveyed believed while it was unusual for judges to disbelieve police testimony, it was not rare.¹⁴⁵ Cloud suggests that one reason may be that judges do not like to call police liars. Even so, the court's complicity in the police's impropriety and professional misconduct constitutes a miscarriage of justice.¹⁴⁶

The expertise of the psychiatrist within the criminal justice system is still generally undisputed, which can allow their judgement to go unquestioned¹⁴⁷ even though the reliability of psychiatric evidence has been the subject of significant academic discussion in recent decades.¹⁴⁸ While contemporary psychiatric evidence is likely

¹⁴⁰ Ibid 1312.

¹⁴¹ Gisli Gudjonsson, 'Disputed Confessions and Miscarriages of Justice in Britain: Expert Psychological and Psychiatric Evidence in the Court of Appeal' (2006) 31 *Manitoba Law Journal* 489.

¹⁴² Myron W Orfield, 'Deterrence, Perjury, and the Heater Factor: An Exclusionary Rule in the Chicago Criminal Courts' (1992) 63 *University of Colorado Law Review* 100.

¹⁴³ Ibid.

¹⁴⁴ Ibid.

¹⁴⁵ Ibid.

¹⁴⁶ Gudjonsson, above n 93.

¹⁴⁷ Gregory Dolin, 'A healer or an executioner? The proper role of a psychiatrist in a criminal justice system' (2002) 48 *Journal of Law and Health* 169.

¹⁴⁸ Matthew Large, Olav Nielssen and Gordon Elliott, 'Reliability of psychiatric evidence in serious criminal matters: fitness to stand trial and the defence of mental illness' (2009) 43 *Australian and New Zealand Journal of Psychiatry* 446. See also Joanmarie I Davoli, 'Psychiatric Evidence on Trial' (2003) 56 *Southern Methodist University Law Review* 2191.

See also Christopher Slobogin, 'Psychiatric Evidence in Criminal Trials: To Junk or Not To Junk?' (1998) 40 *William and Mary Law Review* 1.

to be presented to the court in a self-consciously scientific style, it is not based on any better science than it was in the past, just more commonly couched in scientific terms.¹⁴⁹ Despite research that shows that psychiatrists do it rather poorly, courts take a lenient approach to their predictions of a defendant's future violence.¹⁵⁰ The tendency of judges is to ignore the reliability of the evidence and focus instead on its general acceptance.¹⁵¹ They undertake only a cursory review of the qualifications of the expert.¹⁵² Courts often, and unquestioningly, accept unreliable psychiatric evidence.¹⁵³ However, judges are given little, if any guidance on how to screen expert evidence to determine the question of admissibility¹⁵⁴ with criminal courts adopting a *laissez-faire* policy in that courts will 'permit the adduction of any expert evidence so long as it is not patently unreliable'.¹⁵⁵

While experts generally must keep questions of fact and opinion separate and, in regard to facts, distinguish clearly between those that the expert knows to be true and those that are assumed to be true, for the psychiatrist expert, unless otherwise indicated, all facts are assumed facts.¹⁵⁶ Courts generally view research data or statistically based information as less helpful than issue testimony.¹⁵⁷ Psychiatrists are often called on to testify on issues that they are not able to intelligently answer such as whether the accused poses a future danger, and yet, they routinely do so.¹⁵⁸ Nor do psychiatrists possess a specialised knowledge that enables them to answer moral questions such as 'did the accused know 'right from wrong' or 'good from evil'? When asked to provide the court with a medical answer to what is essentially a moral question, they may try to justify the judgment of the court, or alternatively, substitute their own morality,¹⁵⁹ both of which are pretextual processes. It appears that the pretext of scientific expertise is given greater weight by the court than other, competing versions of 'truth' in evidence, if the competing

¹⁴⁹ Christopher Slobogin, 'Psychiatric Evidence in Criminal Trials: To Junk or Not To Junk?' (1998) 40 *William and Mary Law Review* 1.

¹⁵⁰ David Faigman *et al.*, *Science in the Law: Social and Behavioral Science Issues* (West Group, 2002) 80.

¹⁵¹ Joanmarie I Davoli, 'Psychiatric Evidence on Trial' (2003) 56 *Southern Methodist University Law Review* 2191.

¹⁵² Slobogin, above n 101.

¹⁵³ *Ibid.* See also Davoli, above n 151.

¹⁵⁴ The Law Commission, *The Admissibility Of Expert Evidence In Criminal Proceedings In England And Wales: A New Approach To The Determination Of Evidentiary Reliability*, Consultation Paper No 190 (2009) 3.13 <http://lawcommission.justice.gov.uk/docs/cp190_Expert_Evidence_Consultation.pdf>.

¹⁵⁵ *Ibid* 3.14.

¹⁵⁶ Keith J B Rix, 'The psychiatrist as expert witness' (2008) 14 *Advances in Psychiatric Treatment* 37.

¹⁵⁷ Richard E Redding, Marnita Y Floyd and Gary L Hawk, 'What judges and lawyers think about the testimony of mental health experts: a survey of the courts and bar' (2005) 19 *Behavioral Sciences & the Law* 583.

¹⁵⁸ Dolin, above n 99.

¹⁵⁹ *Ibid.*

truth suggests that the court should be less fearful of the accused, and their future actions.

7.2 Civil commitment pretextuality

It is civil commitment law that, arguably, provides the forum in which pretextuality is most apparent. The involuntary process is a subordinate legal adjunct to the clinical act of depriving an individual of their fundamental right to freedom. It is a process in which treatment and control have been conceptually, and in practice, intertwined even when the written law, such as the Tasmanian *Mental Health Act* 2013, clearly distinguishes the concepts.¹⁶⁰ It is a system that has as its function and aim, to take care of those residual cases that are viewed as problematic by, and for, society.¹⁶¹

Civil commitment and compulsory treatment regulations are the result of the combination of the state's *parens patriae* and police powers so as to deprive a citizen of their fundamental rights, or impose on them, discriminatory conditions that but for the authority of a mental health act, would be unlawful. Under its police power, the state acts to protect people from harm to themselves or others and under its *parens patriae* power, it coercively intervenes in the lives of people, who it is alleged, lack the capacity to make decisions in their own best interests. 'Best interests', it seems, is a separate, and overriding concept to those of 'competence' and 'informed choice'.

The state is deemed to be duty bound to paternalistically act in the subjective 'best interests' of its citizens experiencing mental illness. This belief was expressed in Tasmania's Mental Health Act Review Discussion Paper in 2007:

It is considered that when a person has a treatable mental illness and as a result of that mental illness, the person is a danger to themselves or others, the State has a duty to intervene and provide treatment to that person, even though they

¹⁶⁰ Dallaire *et al.*, above 19.

¹⁶¹ Paul S Appelbaum, 'Almost a revolution: an international perspective on the law of involuntary commitment' (1997) 25 *Journal of the American Academy of Psychiatry and Law* 135.

may have made a competent and informed choice not to consent to treatment.¹⁶²

Psychiatric treatment is a politically discriminate pretext used to impose conformity of lifestyle and behaviour on a particular marginalised group. Laws that focus on the protection of a person's individual rights and freedoms inevitably encounter resistance from the authorities responsible for their application. This is because rights laws contradict the system of social values in which people experiencing mental illness are perceived by society to need help and care - treatment - more than they need freedom.¹⁶³ One U.S. study on mandated care found that 78% of the mental health professionals surveyed believed that legal compulsion made it more likely that the person would stay in treatment.¹⁶⁴ Eighty one percent did not believe that the fear of being compelled would deter someone from seeking treatment although 36% of patients said that it would deter them from seeking help. Of the patients who had had past experience of having been legally compelled, 68% said that it would deter them in future.¹⁶⁵

Dorfman suggests that it is the fear of mental illness that plays a significant role in the decision to involuntarily commit.¹⁶⁶ When 'decisions are predominately a result of our fears, rather than based on the evidence presented, they become pretextual and potentially antitherapeutic'.¹⁶⁷ Such decisions to hospitalise or forcibly medicate are often pretextual because they are not necessarily appropriate to the needs of the person in all instances, and are contrary to what the person wants. Most often, 'it is what the individual decision maker and society wants'.¹⁶⁸ When the decision-making composite of admission and review hold sanist attitudes, it is logical to suggest that it is ordinary common sense, heuristic reasoning, sympathy rather than empathy, and fear and anxiety that guide the decision-makers to seek, and favour, the facts that support and reinforce their conscious, or unconscious

¹⁶² Department of Health and Human Services, 'Review of the *Mental Health Act 1996*' (Discussion Paper, Department of Health and Human Service, August 2007) 16.

¹⁶³ Appelbaum, above n 113.

¹⁶⁴ Marvin Swartz, Jeffrey W Swanson and Michael J Hannon, 'Does Fear of Coercion Keep People Away from Mental Health Treatment? Evidence from a Survey of Person's with Schizophrenia and Mental Health Professionals' (2003) 21 *Behavioral Sciences and the Law*, 459.

¹⁶⁵ Ibid.

¹⁶⁶ Deborah A Dorfman, 'Through a Therapeutic Jurisprudence Filter: Fear and Pretextuality in Mental Disability Law' (1993) 10 *New York Law School Journal of Human Rights* 805.

¹⁶⁷ Ibid 811–12.

¹⁶⁸ Ibid 812.

biases, and to ignore, distort and dismiss information that might direct them toward reaching a less desired but more just decision.

8. JUDICIAL DECISION-MAKING

The legal realist's caricature of justice is that it is whatever the judge ate for breakfast.¹⁶⁹ Realists argue that, contrary to the formalist's position that judges apply legal reasons to the facts of a case in a rational, mechanical, and deliberative manner; judicial decisions are influenced by psychological, political, and social factors.¹⁷⁰ A formalist judge is said to arrive at the answer to 'what ought I do?' only after giving the situation reflective thought, deliberation and calculation. The more accurate the factual and causal information that they have at their disposal, the more likely it is that they will know which one action, amongst all of the actions that they have available to them, is the one most likely to be the right one.¹⁷¹

In contrast, the realist judge is said to act on hunches and gut instincts: intuition - the ability to understand something immediately, without the need for conscious reasoning.¹⁷² The right answer is something that they know or consider likely from instinctive feeling (rather than conscious reasoning to reach conclusions) that they later rationalise with deliberative reasoning so as to justify their intuition. This latter deliberation also ensures that others might see a path of the logical steps that were followed to reach the decision.¹⁷³ Intuitive responses are reached effortlessly and typically, 'without conscious awareness'.¹⁷⁴

Realistic formalists posit that if left to an either or situation, deliberative decision making is more likely than intuitive decision-making to lead to just outcomes, although they do acknowledge the importance of the judicial hunch and the 'importance of deliberation in constraining the inevitable, but often undesirable,

¹⁶⁹ Alex Kozinski, 'What I Ate for Breakfast and Other Mysteries of Judicial Decision Making' (1993) 26 *Loyola of Los Angeles Law Review* 993.

¹⁷⁰ Burt Neuborne, 'Of Sausage Factories and Syllogism Machines: Formalism, Realism, and Exclusionary Selection Techniques' (1992) 67 *New York University Law Review* 419.

¹⁷¹ Robert P Sylvester, *The Moral Philosophy of G.E. Moore* (Temple University Press, 1990).

¹⁷² Bruce Moore (ed), *The Australian Concise Oxford Dictionary* (Oxford University Press, 5th ed, 2009).

¹⁷³ Chris Guthrie, Jeffrey J Rachlinski and Andrew J Wistrich, 'Blinking on the Bench: How Judges Decide Cases' (2007-2008) 93 *Cornell Law Review* 1.

¹⁷⁴ Robin M Hogarth, 'On the Learning of Intuition' in Henning Plessner, Cornelia Betsch and Tilmann Betsch (eds), *Intuition in Judgment and Decision Making* (Taylor and Francis e-Library, 2010) 92. See also Robin M Hogarth, *Educating Intuition* (The University of Chicago Press, 2001) 14.

influence of intuition'.¹⁷⁵ For this reason, they suggest the marrying of the two adjudication models, arguing that by following this realistic formalistic dual-process model, judges will make initial intuitive judgments that are then monitored by a deliberative process that will endorse, correct or override the immediate intuitive judgement. In this way, judges are viewed, not as the formalist's purely deductive decision-maker, or the realist's intuitive rationaliser but as 'ordinary people who tend to make intuitive decisions, but who can override their intuitive reactions with complex, deliberative thought'.¹⁷⁶ It is this complex, deliberative thought process that is often most noticeably absent from decisions in which a party has a mental illness.

8.1 Principlism

Dworkin's theory of principlism¹⁷⁷ argues in defence of the realists that judges choose universally accepted moral values such as autonomy, beneficence, non-maleficence, and justice¹⁷⁸ as their guides for determining which of the principles they will apply, based on the notion of property of weight. Principles may conflict, and most typically do and when they do, the conflict is resolved by selecting the position that is supported by the principles that have the greatest aggregate weight.¹⁷⁹

Beauchamp and Childress' Four Principles approach - respect for autonomy, beneficence, non-maleficence and justice - is the most widely used framework in medical ethics decision-making.¹⁸⁰ The Principles function as a checklist of considerations but do not offer specific direction for action. This is due, in part, to the fact that each principle includes quite separate moral matters that are unrelated by system considerations, and each case may have a number of competing principles which means having to use a number of conflicting moral theories to arrive at a decision.¹⁸¹ The relevant principles in each case will be those moral

¹⁷⁵ Guthrie, Rachlinski and Wistrich, above n 125, 3.

¹⁷⁶ Ibid 3.

¹⁷⁷ Ronald Dworkin, *Taking Rights Seriously* (Harvard University Press, 1977).

¹⁷⁸ DeMarco, J P, 'Principlism and moral dilemmas: and new principle' (2005) 31 *Journal of Medical Ethics* 101.

¹⁷⁹ Ronald Dworkin, 'The Model of Rules I,' reprinted in *Taking Rights Seriously* (Harvard University Press, 1977).

¹⁸⁰ Tom L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (Oxford University Press, 2nd ed, 1983).

¹⁸¹ K Danner Clouser and Bernard Gert, 'A Critique Of Principlism' (1990) 15 *Journal of Medical Philosophy* 219, 221.

values that the judge has identified as being necessary to make the case, and one or more of them will provide the ‘one right answer’ to any legal question.¹⁸² As every person holds their own unique perspectives and preferences, the decision-maker will make the decision that is internally consistent and rational to them.

The pragmatics of principlism can be seen in the Jehovah Witness blood transfusion cases which show that without compelling competing circumstances, judges will invariably give more weight to a child’s right to life than they will to a parent’s right to decide their child’s medical treatment.¹⁸³ Judges are unwilling to deprive a child of the reasonably good chance of survival, recovery and/or quality of life that a blood transfusion can offer them even when the child has reached a *Gillick*¹⁸⁴ level of understanding and has expressed a clear and unshakeable objection to a blood transfusion on religious grounds.¹⁸⁵ This moral value given to a child’s life has received statutory authority in many jurisdictions, where it is lawfully permitted for blood transfusions to be given to minors without parental consent.¹⁸⁶ In family law, the value placed on a perception of a child’s health and wellbeing overrides the value placed on the parent’s responsibility to parent when the parent has a mental illness.¹⁸⁷ This is discussed more fully in Chapter Six.

The often asked question for decision-makers is whether they can, in all good conscience, fail to make a beneficent decision when the necessary legal elements are not met, but the consequences of making the legally correct decision is that the person is left hopelessly unwell, uncared for, and untreated: an entirely morally unsatisfactory situation. This issue was originally addressed by Darold Treffert in his seminal article, ‘Dying with Their Rights On’.¹⁸⁸ Treffert claimed that the pendulum had swung from stifling paternalism to outright abandonment of people with a mental illness who were fronting the commitment process. He called on

¹⁸² Valerie Williams, ‘The Challenge for Australian Jurisdictions to Guarantee Free Qualified Representation Before Mental Health Tribunals and Boards of Review: Learning from the Tasmanian Experience’ (2009) 16 *Psychology and Law* 108.

¹⁸³ *Re S (a minor) (medical treatment)* [1993] 1 FLR 376.

¹⁸⁴ *Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402.

¹⁸⁵ *Re E (a minor)* [1993] 1 FLR 386.

¹⁸⁶ *Human Tissue Act* 1985 (Tas) s 21.

¹⁸⁷ *Carson v. Elrod*, 411 F Supp 645, 649; DC E.D. VA (1976) ‘No bond is more precious and none should be more zealously protected by the law as the bond between parent and child’.

¹⁸⁸ Darold A Treffert, ‘Dying with Their Rights On’ (1973) 130 *American Journal of Psychiatry* 1041. The article was included in Jill Peay’s, *Seminal Issues in Mental Health Law*, Ashgate, Farnham, 2005.

decision-makers to give a proper weighing and balancing to not only the right to freedom and the right to be ill, but also the right to be rescued.¹⁸⁹

The Rescue Principle is an intuitive morality principle that holds that it is morally obligatory to act to prevent another person's preventable death or grave misfortune as long as the rescuer does not risk their own life or safety, or violate other, more fundamental principles.¹⁹⁰ 'If we can prevent something very bad from happening to someone by making a slight or even moderate sacrifice, it would be wrong not to do so'.¹⁹¹ Typically, the rescuer is shocked by the person's desperate circumstances and feels that they have an obligation to provide assistance.¹⁹² This ideal sense of obligation flourishes in mental health matters where decision-makers weight beneficence heaviest so as to ensure that the person is guaranteed a health outcome, not necessarily a just outcome. Although decision-makers try to be objective, impartial, and unbiased they are motivated to arrive at a desired outcome – to see the person become healthy and happy – which conflicts with the motive to be unbiased.¹⁹³

8.2 Bias

Nobody outside of a baby carriage or a judge's chamber believes in an unprejudiced point of view.

Lillian Hellman, US dramatist (1905 - 1984)

Mental health decision-making is built on beliefs about the likelihood of uncertain events happening, commonly expressed in terms such as 'it appears likely,' 'there is a clear possibility' and 'it is not improbable'. These assessments of the probability of an uncertain event happening rely on a limited number of heuristic principles that reduce complex tasks of assessing probabilities and predicting values to simpler judgmental operations. A rational judge will attempt to make probability judgments compatible with their knowledge about the subject matter, the laws of probability, and their own judgmental heuristics and biases. Automatic, heuristic-based snap

¹⁸⁹ Jill Peay, *Seminal Issues in Mental Health Law* (Ashgate Aldershot, 2005) 5.

¹⁹⁰ Brian H Ross, (ed), *The Psychology of Learning and Motivation: Advances in Research and Theory* (Elsevier Academic Press, 2004). See also John Mikhail, 'Moral Grammar and Intuitive Jurisprudence: A Formal Model of Unconscious Moral and Legal Knowledge'. In Daniel Bartels *et al.*, (eds), *Psychology of Learning and Motivation*, Volume 50 (Academic Press, 2009).

¹⁹¹ Thomas Nagel Scanlon, *What We Owe to Each Other* (Harvard University Press, 1998) 224.

¹⁹² John McKie and Jeff Richardson, 'The Rule of Rescue' (2003) 56 *Social Science & Medicine* 2407.

¹⁹³ Michael I Norton, Joseph AVandello and John M Darley, 'Casuistry and Social Category Bias' (2004) 87 *Journal of Personality and Social Psychology* 817.

judgments, although surprisingly accurate at times, lack the deliberative processes often necessary for good judgment which, in turn, can lead to erroneous judicial decisions.¹⁹⁴ While heuristics are generally useful they can lead to ‘severe and systematic errors’¹⁹⁵ when subjective probabilities determine a judge’s preferences. There is no simple formal procedure for assessing the compatibility of a set of probability judgments with the judge’s total system of beliefs.¹⁹⁶

Geyh suggests that ‘judicial impartiality’ is a ubiquitous, feel-good term similar to ‘puppies’ that has been used and misused, under-theorised and haphazardly analysed, to ‘make legal arguments, score political points, exhort judges and reassure the public’.¹⁹⁷ An oath to adjudicate impartially does not ensure impartiality in decision-making as bias is the consequence of life’s experiences. What judges privately think they do, what they publically state that they do, and what they actually do when making decisions differs.¹⁹⁸ While some commentators suggest that judges are not as vulnerable to biased decision-making as others suggest because they have a ‘chronic awareness of potential biases’¹⁹⁹ as well as having specific rules to help reduce attitudinal influences,²⁰⁰ it is naive to think that promises, training and procedural principles can divorce a judge from his or her life’s experiences. ‘Prejudices are fixed and largely immovable’.²⁰¹

It would be foolish to assert that when judges are engaged in solving problems all of their personal attitudes and values become dissipated in the bright glow of objectivity.²⁰²

Judges that adopt, and give power to myths or stereotypes about a group are biased.²⁰³ Reliance on false, stereotypical beliefs regarding deceptive behaviour can

¹⁹⁴ Guthrie, Rachlinski and Wistrich, above n 125.

¹⁹⁵ Daniel Kahneman and Amos Tversky, ‘Judgment under Uncertainty: Heuristics and Biases’ (1974) 185 *Science* 1124, 1124.

¹⁹⁶ Ibid

¹⁹⁷ Charles G Geyh, ‘The Dimensions of Judicial Impartiality, Social Science Research Network’ (2013) 65 *Florida Law Review* 493.

¹⁹⁸ Mandeep K Dhami and Peter Ayton, ‘Bailing and Jailing the Fast and Frugal Way’ (2001) 14 *Journal of Behavioural Decision Making* 141.

¹⁹⁹ Eileen Braeman, *Law, Politics and Perception: How Policy Preferences Influence Legal Reasoning* (University of Virginia Press, 2009) 32.

²⁰⁰ Ibid.

²⁰¹ Stuart, Arboleda-Florez and Sartorius, above n 17, 79.

²⁰² Lon L Fuller, ‘An afterword: Science and the judicial process’ (1966) 79 *Harvard Law Review* 1604, 1619.

²⁰³ Gerarda J Brown, ‘Sweeping Reform from Small Rules, Anti-Bias, Canons as a Substitute for Heightened Scrutiny’ (2000) 83 *Minnesota Law Review* 363, 371.

lead to a biased ‘tunnel vision’ view of the facts.²⁰⁴ Porter et al. suggests that judges make rapid intuitive assessments of dangerousness and trustworthiness that are enduring in nature; influencing subsequent inferences concerning the person making their decision-making about the person increasingly irrational.²⁰⁵ Judges are susceptible to critical thinking errors and their reliance on false stereotypes is used to justify their initial, unreliable assessment.²⁰⁶ As chapter six will show, this seems to be the case in family law courts where the judge intuitively ‘knows’ that a parent experiencing a mental illness is a bad parent and will therefore unconsciously, or even consciously, shape the evidence to support that premise, an implication which is discussed further in chapter six.

People experiencing a mental illness are generally perceived to be less honest and less credible.²⁰⁷ A key role for any judge is to decide the credibility of the parties to any matter: who is lying and who is telling the truth.²⁰⁸ When an allegation of mental illness is made against a parent, their veracity, and the reliability of their evidence is immediately brought to the fore of the proceedings. Their evidence may be labelled as imagined, paranoid or delusional, and the testimony given by a person incapable of perceiving the reality of events is commonly believed to be inaccurate and untrue.²⁰⁹ Women, in particular report that they are not treated equally with other women who do not experience a mental illness, and that they are not viewed as credible witnesses.²¹⁰ In attempting to understand the nature of biasing influences on judicial decision-making, researchers suggest that judges can overvalue a single powerful piece of evidence to the extent that all other evidence is

²⁰⁴ Stephen Porter, Leanne ten Brinke and Chantal Gustaw, ‘Dangerous decisions: the impact of first impressions of trustworthiness on the evaluation of legal evidence and defendant culpability’ (2010) 16 *Psychology, Crime & Law* 477, 478.

²⁰⁵ Ibid.

²⁰⁶ Ibid 478. See also Norbert L Kerr, Robert J MacCoun and Geoffrey P Kramer, ‘Bias in Judgment: Comparing Individuals and Groups’ (1996) 103 *Psychological Review* 687.

²⁰⁷ Amy C Watson, Patrick W Corrigan and Victor Ottati, ‘Police Officers’ Attitudes Toward and Decisions About Persons With Mental Illness’ (2004) 55 *Psychiatric Services* 49.

²⁰⁸ Porter and ten Brinke, above n 155.

²⁰⁹ A Question of Justice: Access and Participation for People with Disabilities in Contact with the Justice System, Report of the Disability Council of NSW, 2003.

²¹⁰ Council of Social Service of New South Wales and the Women’s Rights Action Network Australia, ‘Our Rights, Our Voices: A Forum for Women and Community Groups Working with Women to Discuss, Explore and Report on Women’s Rights in NSW’ (Forum Report, Council of Social Service of NSW and the Women’s Rights Action Network Australia, 2004) < http://www.ncoss.org.au/hot/voices/our_rights_our_voices.pdf>.

discounted.²¹¹ Courts often perceive that it is the mental illness that is the problem.²¹²

8.2.1 *Implicit bias*

Greenwald and Banaji suggest people seek to hide their bias so as not to appear prejudiced.²¹³ Their social behaviours may not be entirely within their conscious control but are largely driven by learned stereotypes that operate automatically, implicitly or unconsciously during human interaction.²¹⁴ Implicit attitudes accurately, or inaccurately, identify traces of past experiences that influence attitudes and judgments in a way that is not introspectively known, and provoke favourable, or unfavourable, feelings, thoughts, or actions.²¹⁵ Also known as ‘unconscious bias’ and ‘hidden bias’, the terms are widely used to explain the persistence of discrimination in society. As implicit bias is largely an automatic response, a person does not have time to deliberate on personal characteristics such as race, age, gender and sexual orientation with the result that, although explicitly disavowing prejudice and claiming to be wholly committed to the principles of antidiscrimination, the person will often be surprised to find that they are in fact, biased.²¹⁶

Factors such as race, ethnicity, gender, or mental status can negatively influence the decision maker, albeit unconsciously, although it is highly improbable that the vast majority of judges would accept the proposition that they interpret evidence pretextually as Perlin suggests, or that factors such as mental illness, gender or race adversely influence their decisions. U.S. research has shown, however, that judges imposed 25% higher bail amounts²¹⁷ and 12% longer sentences on black

²¹¹ Mandeep K Dhami and Peter Ayton, ‘Bailing and Jailing the Fast and Frugal Way’ (2001) 14 *Journal of Behavioural Decision Making* 141.

²¹² Maria Karras *et al.*, ‘On the edge of justice: the legal needs of people with a mental illness in NSW’ (Study Volume 4, Law and Justice Foundation of New South Wales, 2006) <[http://www.lawfoundation.net.au/ljf/site/articleIDs/CB05FD97AAF2458CCA25718E00014293/\\$file/mental.html](http://www.lawfoundation.net.au/ljf/site/articleIDs/CB05FD97AAF2458CCA25718E00014293/$file/mental.html)>.

²¹³ Anthony G Greenwald and Mahzarin Banaji, ‘Implicit social cognition: Attitudes, self-esteem, and stereotypes’ (1995) 102 *Psychological Review* 4.

²¹⁴ *Ibid.*

²¹⁵ *Ibid.* 8.

²¹⁶ Anthony G Greenwald and Linda Hamilton Krieger, ‘Implicit Bias: Scientific Foundations’ (2006) 94 *California Law Review* 955.

²¹⁷ Ian Ayres and Joel Waldfoegel, ‘A Market Test for Race Discrimination in Bail Setting’ (1994) 46 *Stanford Law Review* 987.

defendants²¹⁸ compared to similarly placed, white defendants. They were also more likely to impose the death penalty on a black defendant.²¹⁹ A recent Australian study found that people with schizophrenia were more than twice as likely the rest of the community to have been found guilty and convicted of an offence.²²⁰ Everyone has a tendency to interpret information in ways that confirm their pre-existing beliefs and attitudes about themselves and their social world²²¹ and even the most egalitarian of judges can harbour invidious mental associations.²²² Judges are more likely to associate cues of violence, neglect, unpredictability, instability, poverty, and inadequate parenting skills with a parent who has a mental illness than with a parent who does not.

8.3 Casuistry

Casuistry is case based reasoning that focuses on pragmatics and precedent rather than rules and theories,²²³ and the specious or subtle reasoning that decision-makers use to help them make difficult choice decisions.²²⁴ It serves to publically justify any questionable decisions while at the same time permitting them to rationalise the decision to themselves and support their view that they are unbiased.²²⁵ It allows decision-makers to creatively structure situations so as to compel their own behaviour.²²⁶ They recruit attributes that support their preferred decision and reshape their importance. This process masks biased decision-making, however, unbiased and legally correct decisions are not always valued as being morally right decisions.

Moral decisions, generally, are the result of quick, automatic evaluations or intuitions that are shaped during the course of the development of a person's

²¹⁸ David B Mustard, 'Racial, Ethnic, and Gender Disparities in Sentencing: Evidence from the U.S. Federal Courts' (2001) 44 *Journal of Law and Economics* 285.

²¹⁹ R Richard Banks, Jennifer L Eberhardt and Lee Ross, 'Discrimination and Implicit Bias in a Racially Unequal Society' (2006) 94 *California Law Review* 1169.

²²⁰ T Short, *et al.*, 'Comparing violence in schizophrenia patients with and without comorbid substance-use disorders to community controls (2013) *Acta Psychiatrica Scandinavica* 1 (Early view, First published online - 4 FEB 2013)

²²¹ William B Swann, Alan Stein-Seroussi and Brian R Giesler, 'Why people self-verify' (1992) 62 *Journal of personality and social psychology* 392.

²²² Guthrie, Rachlinski and Wistrich, above n 125.

²²³ Albert R Jonsen, 'Casuistry as methodology in clinical ethics' (1991) 12 *Theoretical Medicine* 295. See also Albert R Jonsen, *Caustical Reasoning in Medical Ethics*. In Richard Edmund Ashcroft et al (eds), *Principles in Health Care Ethics* (John Wiley & Sons, 2007) 51.

²²⁴ Norton, Vandello and Darley, above n 144, 817.

²²⁵ Ibid.

²²⁶ Ibid 829.

personality by their internalisation of social and cultural influences.²²⁷ The function of the thinking process is restricted to formulating *post hoc* justifications for a judgment that is based on the decision-maker's feelings about what they consider to be right or wrong. Social value orientation is expressed automatically in intuitive behaviour²²⁸ and most normative theories of decision-making view it as a process requiring trade-offs between values.²²⁹ The disadvantage from one value is compensated by the benefit of another value.²³⁰ In matters of mental illness, the values of health and treatment can often trump other values such as autonomy, liberty, privacy and honesty.

An example of specious reasoning can be drawn from a 2012 case in which a family law judge ordered a 'very Catholic'²³¹ woman with diagnoses of schizophrenia and bipolar to be involuntarily aborted and sterilized, even if it meant she had to be 'coaxed, bribed, or even enticed ... by ruse'²³² into the procedure. The Appeals Court, when reversing the order stated that, 'No party requested this measure ... and the judge appears to have simply produced the requirement out of thin air.'²³³ The judge publically defended her ruling by claiming to have 'known' that the woman would have chosen to have the procedures if she were mentally competent because '[s]he would want to be healthy'.²³⁴

A thing that one 'knows' or considers likely from instinctive feeling rather than conscious reasoning' is defined as intuition²³⁵ which legal formalists suggest should never be used as a substitute for reasoning. However, society generally, and decision-makers specifically, inherently 'know' that people with a mental illness

²²⁷ Jonathan Haidt, 'The emotional dog and its rational tail: A social intuitionist approach to moral judgment' (2001) 108 *Psychological Review* 814.

²²⁸ Gert Cornelissen, Siegfried Dewitte and Luk Warlop, 'Social Value Orientation as a Moral Intuition: Decision-Making in the Dictator Game' (Research Paper, April 2007) <SSRN: <http://ssrn.com/abstract=978469>>. See also Paul A M Van Lange *et al.*, 'From game theory to real life: How social value orientation affects willingness to sacrifice in ongoing close relationships' (1997) 73 *Journal of Personality and Social Psychology* 1330.

²²⁹ Martin Hanselmann and Carmen Tanner, 'Taboos and conflicts in decision making: Sacred values, decision difficulty, and emotions' (2008) 3 *Judgment and Decision Making* 51.

²³⁰ John Rawls, *A Theory of Justice* (Harvard University Press, 1971).

²³¹ 'Ex-judge defends ordering an abortion for woman', *CBS News* (online), 21 February 2012 <http://www.cbsnews.com/8301-201_162-57381855/ex-judge-defends-ordering-an-abortion-for-woman/>.

²³² John Zaremba, 'Decision blasts judge's order to force abortion: Ruling to 'coax' mentally ill woman sparks outrage', *Boston Herald* (online), 18 January 2012 <http://bostonherald.com/news/regional/view/20220118decision_blasts_judges_order_to_force_abortion_ruling_to_coax_mentally_ill_woman_sparks_outrage>.

²³³ *Ibid.*

²³⁴ *Ibid.*

²³⁵ Bruce Moore (ed), *The Australian Concise Oxford Dictionary* (Oxford University Press, 5th ed, 2009).

need treatment because it is a beneficial good that will cure or alleviate symptoms and control undesirable behaviours. They ‘know’ it is in the person’s best interests to be treated because if left untreated, they represent a risk of harm (harm can be defined simply as a deterioration in their illness) to self or others. And they ‘know’ that untreated people exhibit abnormal behaviours, and are unable to function acceptably in society because they have a mental illness, and if it were not for their mental illness, they would reasonably seek treatment of their own accord.

9. CONCLUSION

This chapter has traced the development of Perlin’s dualistic theories of sanism and pretextuality, which he convincingly argues permeate the legal system. He claims stigma, stereotyping and the prejudice associated with mental illness pervade the law and dictate its treatment of people who experience mental illness. This chapter examined the concepts, and language use of the ‘stigma’ and ‘sanism’ terms, and suggests that ‘sanism’ is a more accurate reflection of the prejudiced attitudes of the law’s actors. Perlin controversially contends that rather than offering parties a neutral and equal playing field, the legal system is inherently biased against mental illness, a proposition, which so far, has failed to gain significant mainstream legal following. The likely reason for this is because sanism is largely invisible, socially acceptable, and frequently practised.²³⁶

Sanism is principally evidenced in the observations of those who see its consequences in the legal system but, for the most part, these consequences go unnoticed, or when seen, they are regarded as socially acceptable by most legal actors. It is in this respect that sanism is unlike other prejudices.

Chapter Five has tried to lift the public reassurance veil of impartial and unbiased decision-making by analysing the ways in which decision-makers arrive at their decisions to show that they are not immune to the prejudices associated with mental illness. It examined the law’s reliance on the medical model and the influence of the psychiatric expert in what is essentially a ‘treatment and control’ legal system. Legal decision-makers commonly base their decisions on stereotypical presumptions, heuristic reasoning and a process of balancing and weighing moral

²³⁶ Ingram, above n 53.

values and principles. They perceive the person as erratic, unpredictable, without credibility and likely dangerous. For example, courts commonly view people who have a mental illness as unfit parents, or at the least, are less fit than the other parent who does not have a mental illness. They believe that a person who is refusing treatment must be legally compelled to undergo treatment because their refusal is simply an indicator of the level of unwellness. If they were not so mentally unwell, they would voluntarily seek treatment because good health is a social value held in the highest regard.

Sanism results in outcomes that are often much more restrictive, less fair and less just than outcomes achieved by similarly circumstanced parties who do not have a mental illness. And according to Perlin, the legal system's processes are corrupted by pretextuality, the artifices the system uses to ensure sanist outcomes are achieved. The following chapter will apply a critical lens to Australia's family law parenting legislation and a sample of recent parenting order decisions in order to reveal the sanist consequences of the biased laws and decision-making that resulted in harsher and unfair outcomes for the parties who had experience mental illness, or whom the courts assessed as having a mental illness despite medical evidence to the contrary.

In a rare empirical testing of Perlin's ideas, chapter eight will present the results of quantitative and qualitative data gathered from a large sample of the legal system's future professionals: law students entering and exiting law school. It will analyse the students' levels of sanism and attempt to assess whether student participation in a therapeutic jurisprudence clinical mental health representation program had a positive impact on their attitudes in contrast to students who did not participate in the program. Chapter Seven presents the program, the Mental Health Tribunal Representation Scheme (MHTRS), as a possible solution to sanism. Although there was insufficient consistent data to establish that the MHTRS positively changed the attitudes of law students, it did raise the question on how sanism in the legal system can be eradicated without the aid of law students helping in the construction of a future, fairer legal system for parties with a mental illness.

BIBLIOGRAPHY

A. Articles

- Adler, Ann K, and Otto F Wahl, 'Children's Belief about People Labelled Mentally Ill' (1998) 68 *American Journal of Orthopsychiatry* 321.
- Angermeyer, Matthias C, Andreas Holzinger, and Herbert Matschinger, 'Emotional reactions to people with mental illness' (2010) 19 *Epidemiologia e Psichiatria Sociale* 26.
- Appelbaum, Paul S, 'Almost a revolution: an international perspective on the law of involuntary commitment' (1997) 25 *Journal of the American Academy of Psychiatry and Law* 135.
- Ayres, Ian, and Joel Waldfogel, 'A Market Test for Race Discrimination in Bail Setting' (1994) 46 *Stanford Law Review* 987.
- Banks, R Richard, Jennifer L Eberhardt, and Lee Ross, 'Discrimination and Implicit Bias in a Racially Unequal Society' (2006) 94 *California Law Review* 1169.
- Birnbaum, Morton, 'The Right to Treatment' (1960) 46 *American Bar Association Journal* 499.
- Birnbaum, Rebecca, 'My Father's Advocacy for a Right to Treatment' (2010) 38 *Journal of the American Academy of Psychiatry and Law* 115.
- Blaska, Betty 'First Person Account: What It Is Like to Be Treated Like a CMI' (1991) 17 *Schizophrenia Bulletin* 173.
- Borg, Marit, Bengt Karlsson, and Hesook S Kim, 'User involvement in community mental health services – principles and practices' (2009) 16 *Journal of Psychiatric and Mental Health Nursing* 285.
- Brown, Gerarda J, 'Sweeping Reform from Small Rules, Anti-Bias, Canons as a Substitute for Heightened Scrutiny' (2000) 83 *Minnesota Law Review* 363.
- Burris, Scott, 'Stigma and the Law' (2006) 367 *The Lancet* 529.
- Byrne, Peter, 'Challenging healthcare discrimination' (2010) 16 *Advances in Psychiatric Treatment* 60.
- Byrne, Peter, 'Stigma of mental illness and ways of diminishing it' (2000) 6 *Advances in Psychiatric Treatment* 65.
- Chamberlin, Judi, 'The Ex-Patients' Movement: Where We've Been and Where We're Going' (1990) 11 *The Journal of Mind and Behavior* 323.
- Champine, Pamela R, 'A Sanist Will' (2002) 46 *New York School of Law Review* 547.
- Chodoff, Paul, 'Involuntary hospitalization of the mentally ill as a moral issue' (1984) 14 *The American Journal of Psychiatry* 384.
- Cloud, Morgan, 'The Dirty Little Secret' (1994) 43 *Emory Law Journal* 1311.

- Clouser, K Danner, and Bernard Gert, 'A Critique Of Principlism' (1990) 15 *Journal of Medical Philosophy* 219.
- Corrigan, Patrick W, and Amy C Watson, 'Understanding the impact of stigma on people with mental illness' (2002) 1 *World Psychiatry* 16.
- Dallaire, Bernadette, *et al.*, 'Civil commitment due to mental illness and dangerousness: the union of law and psychiatry within a treatment-control system' (2000) 22 *Sociology of Health & Illness* 679.
- Darold A Treffert, 'Dying with Their Rights On' (1973) 130 *American Journal of Psychiatry* 1041.
- Davoli, Joanmarie I, 'Psychiatric Evidence on Trial' (2003) 56 *Southern Methodist University Law Review* 2191.
- DeMarco, J P, 'Principlism and moral dilemmas: and new principle' (2005) 31 *Journal of Medical Ethics* 101.
- Dhami, Mandeep K, and Peter Ayton, 'Bailing and Jailing the Fast and Frugal Way' (2001) 14 *Journal of Behavioural Decision Making* 141.
- Dolin, Gregory, 'A healer or an executioner? The proper role of a psychiatrist in a criminal justice system' (2002) 48 *Journal of Law and Health* 169.
- Dorfman, Deborah A, 'Through a Therapeutic Jurisprudence Filter: Fear and Pretextuality in Mental Disability Law' (1993) 10 *New York Law School Journal of Human Rights* 805.
- Eastman, Nigel, 'Mental health law: civil liberties and the principle of reciprocity' (1994) 308 *British Medical Journal* 43.
- Ellis, Heather S, 'Dealing With Mental Disability in Trust & Estate Law Practice: "Strengthen the Things that Remain:" The Sanist Will' (2003) 46 *New York Law School Journal of International & Comparative Law* 565.
- Fuller, Lon L, 'An afterword: Science and the judicial process' (1966) 79 *Harvard Law Review* 1604.
- Garvey, Stephen P, 'The Emotional Economy of Capital Sentencing' (2000) 75 *New York University Law Review* 26.
- Gewirtz, Paul, 'Notes and Comments, Methadone Maintenance for Heroin Addicts' 1969) 78 *The Yale Law Journal* 1175.
- Geyh, Charles G, 'The Dimensions of Judicial Impartiality, Social Science Research Network' (2013) 65 *Florida Law Review* 493.
- Gostin, Larry O, 'Contemporary, Social Historical Perspectives on Mental Health Reform' (1983) 10 *Journal of Law and Society* 47.
- Gould, Keri A, "'Madness in the Streets" Rides the Waves of Sanism' (1992) 9 *New York Law School Journal of Human Rights* 567.
- Grant, George M, 'Donaldson, Dangerousness, and the Right to Treatment' (1976) 3 *Hastings Constitutional Law Quarterly* 599.

Greenwald, Anthony G, and Linda Hamilton Krieger, 'Implicit Bias: Scientific Foundations' (2006) 94 *California Law Review* 955.

Greenwald, Anthony G, and Mahzarin Banaji, 'Implicit social cognition: Attitudes, self-esteem, and stereotypes' (1995) 102 *Psychological Review* 4.

Guadagno, Rosanna E, Kelton V Rhoades, and Brad J Sagarin, 'Figural vividness and persuasion: capturing the "elusive" vividness effect' (2011) 37 *Personality and Social Psychology Bulletin* 626.

Gudjonsson, Gisli, 'Disputed Confessions and Miscarriages of Justice in Britain: Expert Psychological and Psychiatric Evidence in the Court of Appeal' (2006) 31 *Manitoba Law Journal* 489.

Guthrie, Chris, Jeffrey J Rachlinski, and Andrew J Wistrich, 'Blinking on the Bench: How Judges Decide Cases' (2007-2008) 93 *Cornell Law Review* 1.

Haidt, Jonathan, 'The emotional dog and its rational tail: A social intuitionist approach to moral judgment' (2001) 108 *Psychological Review* 814.

Hanselmann, Martin, and Carmen Tanner, 'Taboos and conflicts in decision making: Sacred values, decision difficulty, and emotions' (2008) 3 *Judgment and Decision Making* 51.

Hutt, Peter Barton, and Richard A Merrill, 'Criminal Responsibility and the Right to Treatment for Intoxication and Alcoholism' (1969) 57 *Georgetown Law Journal* 835.

Jonsen, Albert R 'Casuistry as methodology in clinical ethics' (1991) 12 *Theoretical Medicine* 295.

Kahneman, Daniel, and Amos Tversky, 'Judgment under Uncertainty: Heuristics and Biases' (1974) 185 *Science* 1124.

Kaplan, Honora A, 'Institutions and Community Mental Health: The Paradox in *Wyatt v. Stickney*' (1973) 9 *Community Mental Health Journal* 34.

Kerr, Norbert L, Robert J MacCoun, and Geoffrey P Kramer, 'Bias in Judgment: Comparing Individuals and Groups' (1996) 103 *Psychological Review* 687.

Kisielius, Jolita, and Brian Sternthal, 'Detecting and Explaining Vividness Effects in Attitudinal Judgments' (1984) 21 *Journal of Marketing Research* 54.

Kozinski, Alex, 'What I Ate for Breakfast and Other Mysteries of Judicial Decision Making' (1993) 26 *Loyola of Los Angeles Law Review* 993.

Langford, Lorette, 'The New Mental Health Act in Tasmania (1996): A Comparative Review with the Former Act (1963): "Can They Now Die with Their Rights On?"' (2003) 10 *Psychiatry, Psychology and Law* 140.

Large, Matthew, and Christopher J Ryan, 'Sanism, stigma and the belief in dangerousness' (2012) 46 *Australian & New Zealand Journal of Psychiatry* 1099.

Large, Matthew, Olav Nielssen, and Gordon Elliott, 'Reliability of psychiatric evidence in serious criminal matters: fitness to stand trial and the defence of mental illness' (2009) 43 *Australian and New Zealand Journal of Psychiatry* 446.

Luchins, Daniel J, *et al.*, 'Lawyers' Attitudes Toward Involuntary Treatment' (2006) 34 *Journal of the American Academy of Psychiatry and Law* 492.

McKie, John, and Jeff Richardson, 'The Rule of Rescue' (2003) 56 *Social Science & Medicine* 2407.

Menkel-Meadow, Carrie, 'The Trouble with the Adversary System in a Postmodern, Multicultural World' (1996) 38 *William and Mary Law Review* 5.

Mitchel, Gregory, 'Libertarian Paternalism Is An Oxymoron' (2005) 99 *Northwestern University Law Review* 1245.

Mustard, David B, 'Racial, Ethnic, and Gender Disparities in Sentencing: Evidence from the U.S. Federal Courts' (2001) 44 *Journal of Law and Economics* 285.

Myron W Orfield, 'The Exclusionary Rule and Deterrence: An Empirical Study of Chicago Narcotics Officers' (1987) 54 *University of Chicago Law Review* 1016.

Napier, Jaime L, and John T Jost, 'The "Antidemocratic Personality" Revisited: A Cross-National Investigation of Working-Class Authoritarianism' (2008) 64 *Journal of Social Issues* 595.

Neuborne, Burt, 'Of Sausage Factories and Syllogism Machines: Formalism, Realism, and Exclusionary Selection Techniques' (1992) 67 *New York University Law Review* 419.

Norton, Michael I, Joseph A Vandello and John M Darley, 'Casuistry and Social Category Bias' (2004) 87 *Journal of Personality and Social Psychology* 817.

O'Neil, Kevin M, Marc W Patry, and Steven D Penrod, 'Exploring the Effects of Attitudes Toward the Death Penalty on Capital Sentencing Verdicts' (2004) 10 *Psychology, Public Policy, and Law* 443.

Ogloff, James R P, 'Psychopathy/antisocial personality disorder conundrum' (2006) 40 *Australian New Zealand Journal of Psychiatry* 519.

Orfield, Myron W, 'Deterrence, Perjury, and the Heater Factor: An Exclusionary Rule in the Chicago Criminal Courts' (1992) 63 *University of Colorado Law Review* 100.

Perlin, Michael L, and Deborah A Dorfman, 'Sanism, social science, and the development of mental disability law jurisprudence' (2006) 11 *Behavioral Sciences & the Law* 47.

Perlin, Michael L, '"Half-Wracked Prejudice Leaped Forth": Sanism, Pretextuality, and Why and How Mental Disability Law Developed as it Did' (1999) 10 *Journal of Contemporary Legal Issues* 3.

Perlin, Michael L, '"And My Best Friend, My Doctor/Won't Even Say What It Is I've Got": The Role and Significance of Counsel in Right to Refuse Treatment Cases' (2005) 42 *San Diego Law Review* 735.

Perlin, Michael L, '"His Brain Has Been Mismanaged with Great Skill": How Will Jurors Respond to Neuroimaging Testimony in Insanity Defense Cases?' (2009) 42 *Akron Law Review* 885.

Perlin, Michael L, '"Through the Wild Cathedral Evening": Barriers, Attitudes, Participatory Democracy' (2008) 13 *Texas Journal On Civil Liberties and Civil Rights* 413.

Perlin, Michael L, “‘You Have Discussed Lepers And Crooks”: Sanism In Clinical Teaching’ (2003) 9 *Clinical Law Review* 683.

Perlin, Michael L, ‘On “Sanism”’ (1992-1993) 46 *Southern Methodist University Law Review* 373.

Perlin, Michael L, ‘The sanist lives of jurors in death penalty cases: The puzzling role of “Migrating” mental disability’ (1994) 8 *Notre Dame Journal of Law, Ethics & Public Policy* 239.

Perlin, Michael L, 'They're An Illusion to Me Now': Forensic Ethics, Sanism and Pretextuality' (Research Paper Series No 07/08-27, New York Law School Legal Studies, 2008) <<http://ssrn.com/abstract=1130923>>.

Perlin, Michael L, ‘Executioner's Face Is Always Well-Hidden: The Role of Counsel and the Courts in Determining Who Dies’ (1997) 41 *New York Law School Law Review* 201.

Phelan, Jo C, Bruce G Link, and John F Dovidio, ‘Stigma and prejudice: one animal or two?’ (2008) 67 *Social Science and Medicine* 358.

Piel, Jennifer, ‘Mental Disability Law, Evidence, and Testimony: A Comprehensive Reference Manual for Lawyers, Judges, and Mental Disability Professionals’ (2010) 38 *Journal of American Academy of Psychiatry and the Law* 619.

Poole, Jennifer M, *et al.*, ‘Sanism, ‘Mental Health’, and Social Work/Education: A Review and Call to Action’ (2012) 1 *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice* 20.

Pope, Thaddeus Mason, ‘Counting The Dragon's Teeth And Claws: The Definition Of Hard Paternalism’ (2004) 20 *Georgia State University Law Review* 659.

Popper, Karl, ‘Science : Conjectures and Refutations”, Ch. 1, Section VII, <http://worthylab.tamu.edu/courses_files/popper_conjecturesandrefutations.pdf> 26.

Porter, Stephen, Leanne ten Brinke, and Chantal Gustaw, ‘Dangerous decisions: the impact of first impressions of trustworthiness on the evaluation of legal evidence and defendant culpability’ (2010) 16 *Psychology, Crime & Law* 477.

Pronin, Emily, *et al.*, ‘Objectivity in the Eye of the Beholder: Divergent Perceptions of Bias in Self Versus Others’ (2004) 3 *Psychological Review* 781.

Redding, Richard E, Marnita Y Floyd, and Gary L Hawk, ‘What judges and lawyers think about the testimony of mental health experts: a survey of the courts and bar’ (2005) 19 *Behavioral Sciences & the Law* 583.

Rix, Keith J B, ‘The psychiatrist as expert witness’ (2008) 14 *Advances in Psychiatric Treatment* 37.

Rose, Mary R, Christopher Ellison, and Shari Seidman Diamond, ‘Preferences for Juries Over Judges Across Racial and Ethnic Groups’ (2008) 89 *Social Science Quarterly* 372.

Shapiro, David L, ‘Courts, Legislatures, and Paternalism’ (1988) 74 *Virginia Law Review* 519.

Short, T, *et al.*, 'Comparing violence in schizophrenia patients with and without comorbid substance-use disorders to community controls (2013) *Acta Psychiatrica Scandinavica* 1 (Early view, First published online - 4 FEB 2013)

Shutz, Heidi, and Bernd Six, 'How Strong is the Relationship Between Prejudice and Discrimination? A Meta-Analytic Answer' (1996) 20 *International Journal of Intercultural Relations* 441.

Slobogin, Christopher, 'Mental Illness and the Death Penalty' (2000) 24 *Mental & Physical Disability Law Report* 667.

Slobogin, Christopher, 'Psychiatric Evidence in Criminal Trials: To Junk or Not To Junk?' (1998) 40 *William and Mary Law Review* 1.

Slobogin, Christopher, 'Testilying: Police Perjury And What To Do About It' (1996) 67 *University of Colorado Law Review* 1037.

Slovenko, Ralph, 'The past and present of the right to treatment: a slogan gone astray' (1981) 9 *Journal of Psychiatry and Law* 264.

Steinberger, Claire B, 'Therapeutic Jurisprudence: The Sanist Factor-An Interdisciplinary Approach' (2002) 46 *New York Law School Law Review* 573.

Swartz, Marvin, Jeffrey W Swanson, and Michael J Hannon, 'Does Fear of Coercion Keep People Away from Mental Health Treatment? Evidence from a Survey of Person's with Schizophrenia and Mental Health Professionals' (2003) 21 *Behavioral Sciences and the Law*, 459.

Tanner, Denise, 'Crossing bridges over troubled waters?: Working with children of parents experiencing mental distress (2000) 19 *Social Work Education: The International Journal* 287.

Thornicroft, Graham, *et al.*, 'Stigma: ignorance, prejudice or discrimination?' (2007) 190 *British Journal of Psychiatry* 192.

Treffert, Darold A, 'Dying with Their Rights On' (1973) 130 *American Journal of Psychiatry* 1041.

Van Lange, Paul A M, *et al.*, 'From game theory to real life: How social value orientation affects willingness to sacrifice in ongoing close relationships' (1997) 73 *Journal of Personality and Social Psychology* 1330.

Watson, Amy C, Patrick W Corrigan, and Victor Ottati, 'Police Officers' Attitudes Toward and Decisions About Persons With Mental Illness' (2004) 55 *Psychiatric Services* 49.

William B Swann, Alan Stein-Seroussi, and Brian R Giesler, 'Why people self-verify' (1992) 62 *Journal of personality and social psychology* 392.

Williams, Valerie 'The Challenge for Australian Jurisdictions to Guarantee Free Qualified Representation Before Mental Health Tribunals and Boards of Review: Learning from the Tasmanian Experience' (2009) 16 *Psychology and Law* 108.

Winick, Bruce J, 'The Supreme Court's Evolving Death Penalty Jurisprudence: Severe Mental Illness as the Next Frontier' (2009) 50 *Boston College Law Review* 785.

Winick, Bruce, 'TJ and the Civil Commitment Hearing' (1999) 10 *The Journal of Contemporary Legal Issues* 37.

Zientek, Marybeth, 'Riggins v. Nevada: Medicated Defendants and Courtroom Demeanor from the Jury's Perspective' (1993) 30 *American Criminal Law Review* 215.

B. Books

Ashcroft, Richard Edmund, *et al.*, (eds), *Principles in Health Care Ethics* (John Wiley & Sons, 2007).

Ayd Jr, Frank J (ed), *Medical, Moral, and Legal Issues in Mental Health Care* (Williams & Wilkins, 1974).

Bartels, Daniel, *et al.*, (eds), *Psychology of Learning and Motivation*, Volume 50 (Academic Press, 2009).

Beauchamp, Tom L, and James F Childress, *Principles of Biomedical Ethics* (Oxford University Press, 2nd ed, 1983).

Braeman, Eileen, Law, *Politics and Perception: How Policy Preferences Influence Legal Reasoning* (University of Virginia Press, 2009).

Chamberlin, Judi, *On Our Own: Patient-Controlled Alternatives to the Mental Health System* (McGraw-Hill, 1978).

Diesfeld Kate, and Ian R Freckleton (eds), *Involuntary Detention and Therapeutic Jurisprudence* (Ashgate Publishing Limited, 2003).

Dworkin, Ronald, *Taking Rights Seriously* (Harvard University Press, 1977).

Faigman, David, *et al.*, *Science in the Law: Social and Behavioral Science Issues* (West Group, 2002).

Goffman, Erving, *Stigma: notes on the management of spoiled identity* (Prentice-Hall, 1963).

Gold, Liza H, *Sexual Harassment: Psychiatric Assessment In Employment Litigation* (American Psychiatric Publishing Inc., 2004).

Henning Plessner, Cornelia Betsch, and Betsch, Tilmann, *et al.* (eds), *Intuition in Judgment and Decision Making* (Taylor and Francis e-Library, 2010).

Hogarth, Robin M, *Educating Intuition* (The University of Chicago Press, 2001).

Berkowitz, Leonard (ed), *Advances in experimental social psychology*, Vol. 20, (Academic Press, 1987).

Macquarie Dictionary, (Macquarie University Press, 5th edition, 2009).

Menzies, Robert, Brenda A LeFrançois, and Geoffrey Reaume (eds), *Mad Matters: A Critical Reader in Canadian Mad Studies* (Canadian Scholars' Press Inc., 2013).

Moore, Bruce (ed), *The Australian Concise Oxford Dictionary* (Oxford University Press, 5th ed, 2009).

Parry, John W, *Criminal Mental Health and Disability Law, Evidence and Testimony: A Comprehensive Reference Manual for Lawyers, Judges and Criminal Justice Professionals* (American Bar Association, 2009).

Peay, Jill, *Seminal Issues in Mental Health Law* (Ashgate Aldershot, 2005).

Perlin, Michael L, *et al.*, *Competence in the Law: From Legal Theory to Clinical Application* (John Wiley & Sons, 2008).

Perlin, Michael L, *Mental Disability and the Death Penalty: The Shame of the States* (Rowman & Littlefield Publishers, 2013).

Perlin, Michael L, *The Hidden Prejudice: Mental Disability on Trial* (American Psychological Association, 2000).

Rawls, John, *A Theory of Justice* (Harvard University Press, 1971).

Ross, Brian H (ed), *The Psychology of Learning and Motivation: Advances in Research and Theory* (Elsevier Academic Press, 2004).

Scanlon, Thomas Nagel, *What We Owe to Each Other* (Harvard University Press, 1998).

Stuart, Heather, Julio Arboleda-Florez, and Norman Sartorius, *Paradigms Lost* (Oxford University Press, 2012).

Suber, Peter, 'Paternalism' in Christopher B Gray (ed), *Philosophy of Law: An Encyclopedia* (Garland Publishing, 1999).

Sylvester, Robert P, *The Moral Philosophy of G.E. Moore* (Temple University Press, 1990).

Vandeveer, Donald, *Paternalistic Intervention: The Moral Bounds on Benevolence* (Princeton University Press, 1986).

C. Grey Literature -Research Papers, Reports, Submissions, Letters, Memos etc

'Our Rights, Our Voices: A Forum for Women and Community Groups Working with Women to Discuss, Explore and Report on Women's Rights in NSW' (Forum Report, Council of Social Service of NSW and the Women's Rights Action Network Australia, 2004) < http://www.ncoss.org.au/hot/voices/our_rights_our_voices.pdf>.

'Review of the *Mental Health Act 1996*' (Discussion Paper, Department of Health and Human Service, 2007).

<http://lawcommission.justice.gov.uk/docs/cp190_Expert_Evidence_Consultation.pdf>.

A Question of Justice: Access and Participation for People with Disabilities in Contact with the Justice System, (Report of the Disability Council of NSW, 2003)

Carr, Lauren Wilson, 'Wyatt v. *Stickney*: A Landmark Decision', *Alabama Disabilities Advocacy Program Newsletter* (online), July 2004
<<http://www.adap.net/Wyatt/landmark.pdf>>.

Chalmers, Don, 'University of Tasmania's Dean of Law (Media statement, 2009) <http://www.media.utas.edu.au/__data/assets/pdf_file/0016/12256/Lawfest-FOR-WEB.pdf>.

Cornelissen, Gert, Siegfried Dewitte, and Luk Warlop, 'Social Value Orientation as a Moral Intuition: Decision-Making in the Dictator Game' (Research Paper, 2007) <<http://ssrn.com/abstract=978469>>.

Forrest, Ruth, MLC, Speech to Mental Health Legislative Measures Select Committee - 27 October 2009 <<http://www.ruthforrest.com.au/index.php/parliament/speeches/2009/70-2009-speeches-on-motions/450-mental-health-legislative-measures-select-committee-27-october-2009>>.

Ingram, R., Sanism in Theory and Practice (Conference paper, 2nd Annual Critical Inquiries Workshop, 2011) <<http://www.socialinequities.ca/wordpress/wp-content/uploads/2011/07/Ingram.Sanism-in-Theory-and-Practice.CI.2011.pdf>>.

Kalinowski, Coni and Pat Risser, 'Identifying and Overcoming Mentalism' (Research Paper, InforMed Health Publishing & Training, 2000) <http://counterpsych.com/uploads/23542/uploadedDocuments/Mentalism_07_00.pdf>.

Karras, Maria, *et al.*, 'On the edge of justice: the legal needs of people with a mental illness in NSW' (Study Volume 4, Law and Justice Foundation of New South Wales, 2006) <[http://www.lawfoundation.net.au/ljf/site/articleIDs/CB05FD97AAF2458CCA25718E00014293/\\$file/mental.html](http://www.lawfoundation.net.au/ljf/site/articleIDs/CB05FD97AAF2458CCA25718E00014293/$file/mental.html)>.

Morris, Grant H, 'Pursuing Justice for the Mentally Disabled' (Research Paper, University of San Diego School of Law, Public Law and Legal Theory Research Paper Series, Paper 31, 2005)

Pizzuro, Salvatore, 'The implications of the Atkins Concept on the Lives of People with Disabilities in Criminal and Civil Courts' (Research Paper, 2009) <<http://s395229360.onlinehome.us/Research/Legal/PizzuroOnAtkins%282009%29.pdf>>.

Report of the Expert Committee, 1999. <http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4062614.pdf>.

The Law Commission, *The Admissibility Of Expert Evidence In Criminal Proceedings In England And Wales: A New Approach To The Determination Of Evidentiary Reliability* (Consultation Paper No 190, 2009).

Weiss, Michael, and Cathy Young, 'Feminist Jurisprudence: Equal Rights or Neo-Paternalism?' (Policy Analysis No 256, Cato Institute, 1996) <<http://www.cato.org/publications/policy-analysis/feminist-jurisprudence-equal-rights-or-neopaternalism>>.

D. Legislation and Regulations

Anti-discrimination Act 1998 (Tas)

Human Tissue Act 1985 (Tas)

Mental Health Act 1996 (Tas).

E. Cases

Blunt v. Narcotic Addiction Control Commission, 295 N.Y.S.2d 276 (Sup.Ct) 296 N.Y.S.2d 533 (App. Div. 1968).

Carson v. Elrod, 411 F Supp 645, 649; DC E.D. VA (1976)

Ceschini v. Warden, 30 App. Div. 2d 649 291 N.Y.S.2d 200 (1968) (per curiam).

Gillick v West Norfolk and Wisbech Area Health Authority [1985] 3 All ER 402.

In re Harris, 2 Crim. L. Rep. 2412 (Cook County, Ill., Cir. Ct., Juv. Div. 1967)

Kent v. United States, 401 F.2d 408 (D.C. Cir. 1968).

O'Connor v Donaldson, 422 U.S. 563 (1975).

R. v. S. (R.D.) [1997] 3 S.C.R 484.

Re E (a minor) [1993] 1 FLR 386.

Re S (a minor) (medical treatment) [1993] 1 FLR 376.

Wyatt v. Stickney, 334 F. Supp. 1341, 1343 (M.D. Ala. 1971).

People Of The State Of California Plaintiffs, vs. Orenthal James Simpson, CASE NO. BA 09721, 1995.

F. Media and websites

‘Ex-judge defends ordering an abortion for woman’, (CBS News, 21 February 2012)
<http://www.cbsnews.com/8301-201_162-57381855/ex-judge-defends-ordering-an-abortion-for-woman/>.

Dylan, Bob, *Cold Irons Bound*, Colombia Records.

The Saturday Mercury Newspaper, Tasmania, August 23, 2003.

Zaremba, John, ‘Decision blasts judge’s order to force abortion: Ruling to ‘coax’ mentally ill woman sparks outrage’, (*Boston Herald*, 18 January 2012)
<http://bostonherald.com/news/regional/view/20220118decision_blasts_judges_order_to_force_abortion_ruling_to_coax_mentally_ill_woman_sparks_outrage>.

Kenneth B. Noble, Ruling Aids Prosecution of Simpson, *NewYork Times*, Sept. 20, 1994.
<<http://www.nytimes.com/1994/09/20/us/ruling-aids-prosecution-of-simpson.html>>

CHAPTER SIX

THE LEGAL SYSTEM'S 'SANIST TREATMENT' OF PARENTS WHO EXPERIENCE MENTAL ILLNESS

1. INTRODUCTION

Mental health commentators often refer to the 'special relationship' that exists between mental health and family breakdown;¹ to the high rates of depression, anxiety and substance abuse that occurs amongst adults experiencing divorce or separation;² and to the fact that people with a history of psychiatric problems have much higher marital separation rates than the general population.³ When these family breakdowns reach the family courts in litigated child care proceedings, the law has a tendency to focus its attention on the attributes associated with mental illness.⁴ When a parent's mental illness is raised as an issue, it usually becomes the pivotal issue 'or the case is prepared as though it is'.⁵ Studies show that parents who use the other parent's mental illness as the central focus of a custodial battle win 70-80% of the time⁶ with other studies reporting that as many as 70 % of parents experiencing mental illness lose custody.⁷

The value of alleging a mental illness in a custodial challenge rests in the commonly held belief that the court will stereotypically categorise the parent with the mental illness as potentially violent, abusive and neglectful, and naturally unfit to be a proper parent. This chapter shows that it is this 'unfit parent' stereotype that underpins decision-making where, in accordance with applicable law and policy, it

¹ Bruce Smyth, Nicholas Richardson and Grace Soriano (eds), 'Proceedings of the International Forum on Family Relationships in Transition: Legislative, practical and policy responses' (Australian Institute of Family Studies, 1 – 2 December 2005).

² Bryan Rodgers, 'Mental Health and the Family Law System' (2004) 10 *Journal of Family Studies* 50.

³ Smyth, Richardson and Soriano, above n 1, 239.

⁴ Bruce G Link and Jo C Phelan, 'Conceptualizing stigma' (2001) 27 *Annual Review of Sociology* 363, 375.

⁵ Federal Magistrate Judy Ryan, 'Mental Health and Family Law - A Question of Degree' (Paper presented at 6th Annual Family Law Intensive, Sydney, 11 February 2006)

<<http://federalcircuitcourt.gov.au/pubs/docs/Speech%20-%20Ryan%20-%20mentalhealth%20-%202006.pdf>>.

⁶ Making the Invisible Visible: Parents with Psychiatric Disabilities, National Technical Assistance Center for State Mental Health Planning, Special Issue, Parents with Psychiatric Disabilities, 2000

<<http://www.nasmhpd.org/docs/publications/archiveDocs/2000/ParentswithPsychiatricDisabilities.pdf>>

⁷ Joanna Nicholson, Elaine Sweeney and Jeffrey Geller, 'Mothers with mental illness: II. Family relationships and the context of parenting' (1998) 49 *Psychiatric Services* 643.

is in the best interests of the child it is necessary to separate the parent with a mental illness from the child.⁸ More often than not, the answer is yes because having a mental illness represents a risk that courts find unacceptable.

Society promotes the parent as being in the best position to nurture, protect, and care for the needs of their children⁹ so that when the parent fails, or is unable to protect their child from preventable harm, the state through its *parens patriae* powers is authorised to intervene in the parent-child relationship. But once a parent experiencing mental illness becomes caught up in the non-value-neutral legal system, it is likely that they will be failingly judged against the amorphic standard of the ‘good parent’. The reason for this is largely because the socially defined attributes of bad parenting - neglect, irresponsibility, disorganisation, disinterest, and abusive/violent behaviour - mirror the widely accepted abnormal manifestations of mental illness that were discussed in Chapter Three.

Chapter Five applied a generalist approach to sanism which Perlin argues pervades the legal system inherently biased against mental illness.¹⁰ This chapter applies a sanist lens across the legal area of conflicted parenting in matters in which a parent’s mental illness is an issue for the decision-maker. This particular area for study was chosen because it is (1) a small, well regulated and well reported area of law and (2) because parents experiencing mental illness have been stigmatised and stereotyped as naturally unfit parents long before ever entering the legal system.¹¹ It explores the nature and the extent that the law uses negative stereotypes to influence decision-making in parenting matters to the unfair disadvantage of parents with a mental illness.

This chapter examines the ways that different legal institutions respond to the predictor assessment of parental risk to show that family court decisions tend to have lower thresholds which result in decisions that appear harsher and less fair

⁸ *Convention on the Rights of the Child*, opened for signature 20 November 1987, 1577 UNTS 3 (entered into force 2 September 1990) art 9.

⁹ Jill Goldman *et al.*, ‘A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice’ (Report, U.S. Department of Health and Human Services, Administration for Children and Families Administration on Children, Youth and Families Children’s Bureau, Office of Child Abuse and Neglect, 2003) <<https://www.childwelfare.gov/pubs/usermanuals/foundation/foundation.pdf>>.

¹⁰ Michael L Perlin, *The Hidden Prejudice: Mental Disability on Trial* (American Psychological Association, 2000).

¹¹ When a Parent Has a Mental Illness: Issues and Challenges, Mental Health America website <<http://www.mentalhealthamerica.net/index.cfm?objectid=e3412bb7-1372-4d20-c8f627a57cd3d00f>>.

than child protection decisions. Underlying this unfair treatment is the inextricable link of the ‘mentally ill’ parent to the moral notion of the ‘bad parent’.

Accordingly, the chapter commences with an examination of the good versus bad parent debate as this debate continues to influence significantly the development and implementation of parenting policies and laws, and the interpretation of regulations intended to protect children from risk of harm and ensure that their best interests are met.

It suggests that the ‘potential risks’ identified by the courts are usually defined as ‘unacceptable risks’ even though the great majority of parents do not, as a consequence of mental illness, neglect or harm their children.¹² To test this suggestion, the doctrine of ‘best interests of the child’, and the concept of ‘meaningful relationships’ in Part VII of the *Family Law Act* 1975 were examined which revealed the same conceptual and definitional problems that were reported in Chapter One. Legislative terms were either not defined or had vague meanings and were open to varied judicial interpretations, all of which disadvantaged parents with a mental illness.

This was also the finding of the qualitative review of 296 Australian family law parenting orders made between 2006 and 2011 undertaken as part of this thesis. The sample of case studies generated from the review presented below at Section 5.0 shows that parents with experience of mental illness were at significant risk of having their parental responsibilities severely restricted, or removed entirely. A decision-makers’ personal, though unsubstantiated, belief that a party had a mental illness often predicted their decision that the parent represented an unacceptable risk to the child. The court’s decisions were at times, contrary to the wishes of the other parent and/or were in conflict with the medical evidence provided by the expert witness. The case studies indicated that judges often make personal and prejudicial judgment calls that reflect the values, perceptions and legal interpretations that satisfy their own sense of fairness but risk significantly unfair outcomes for the parent.¹³

¹² Jo Tunnard, ‘Parental mental health problems: messages from research, policy and practice’ (Research Review, Research in Practice, 2004) 44.

¹³ Jay Folberg, ‘Family Courts: Assessing the Trade-Offs’ (1999) 37 *Family Court Review* 448.

2. STEREOTYPING THE PARENT WITH A MENTAL ILLNESS AS ‘UNFIT’

Parenthood is a cherished and highly valued social role within human society:¹⁴ a normative life experience that for many, defines the roles and meaning of adulthood.¹⁵ The societal expectation of parenting is that it will produce an acceptable standard of care and will provide a protective buffer between the child and the harms and adversities that it will encounter through its journey through childhood and adolescence¹⁶ toward the ideal collective outcome of rational and responsible adulthood. How a child responds to, and is affected by the social problems it will encounter such as abuse, truancy, youth crime, teenage pregnancy, educational underachievement, substance misuse and mental illness is considered largely influenced by their parents’ parenting skills.¹⁷

Poor parenting is considered an indicator of impoverished or uninformed parental behaviours and is a predictor of future antisocial behaviours. Poor parenting practices lead to a child’s arrested or maladapted physical, emotional and/or psychological development, and are proximal mechanisms for increasing levels of antisocial behaviour.¹⁸ Studies of different parenting styles have, for example, identified close associations between inadequate parental management and premature autonomy and juvenile offending¹⁹, and adolescent drinking, and other

¹⁴ Barry J Ackerson, ‘Parents with serious and persistent mental illness: Issues in assessment and services’ (2003) 48 *Social Work* 187.

¹⁵ Joanne Nicholson, Elaine M, Sweeney, Jeffrey L Geller, ‘Focus on Women: Mothers with Mental Illness: I. The Competing Demands of Parenting and Living With Mental Illness’ (1998) 49 *Psychiatric Services* 635.

¹⁶ Daphne Blunt Bugental and Joan E Grusec, ‘Socialization Process’ in William Damon, Richard M Lerner (eds), *Handbook of Child Psychology: Social, emotional, and personality development* (John Wiley & Sons, 2006) 366.

¹⁷ It is much easier to identify the characteristics of a bad parent who is neglectful, irresponsible, disorganized, disinterested, abusive, etc. Good parenting tends to be viewed as a conglomeration of different common sense attributes such as responsibility, kindness and understanding, sense of humour, stability of personality, similar values and beliefs, and faithfulness/loyalty.

¹⁸ John F Knutson, David S DeGarmo and John B Reid, ‘Social Disadvantage and Neglectful Parenting as Precursors to the Development of Antisocial and Aggressive Child Behavior: Testing a Theoretical Model’ (2004) 30 *Aggressive Behavior* 187.

¹⁹ United Nations, ‘World Youth Report 2003: The global situation of young people’ (Report, Secretary-General, 2003) 195 <www.un.org/esa/socdev/unyin/documents/worldyouthreport.pdf>. “Studies show that children who receive adequate parental supervision are less likely to engage in criminal activities.”

negative behaviours²⁰ that can be precursors of the future adult's problems with alcoholism²¹, criminality²², poverty²³, homelessness²⁴ and mental illness.²⁵

Also linked to the undisciplined, antisocial, insecure and aggressive behaviours expressed by a child are the commonly accepted intergenerational²⁶ characteristics of bad parenting: neglectful, irresponsible, disorganised, disinterested, and/or abusive parental behaviours.²⁷ Children of abusive parents are also considered to represent a far greater risk of perpetrating abuse within their own parenting regimes.^{28 29} However, intervention is frequently viewed as difficult in those situations where a child is emotionally and/or psychologically abused by a parent's rejecting, isolating, terrorising, ignoring, corrupting, verbally assaultive and/or over-pressurizing behaviours due to the intangible nature of the type of abuse.³⁰ This form of emotional/psychological abuse is commonly associated with mental illness.

The types of provoking actions indicative of emotional and psychological abuse of children by parents are often publically and professionally accepted as demonstrations of bad parenting rather than the abusive actions of abusive parents, thereby negating any expectation of legal intervention by the state.³¹ For example, psychiatrists have labelled mild emotional abuse as a form of 'bad parenting' that is often administered by a misguided, yet caring parent and because the abuse is not perpetrated with malicious intent and does not contain an immediate danger of

²⁰ Anna Stewart, Susan Dennison and Elissa Waterson, 'Pathways from Child Maltreatment to Juvenile Offending' (Research Paper No 241, Australian Institute of Criminology, 2002).

²¹ Gregory T Smith, 'Psychological Expectancy as Mediator of Vulnerability to Alcoholism' (1994) 708 *Annals of the New York Academy of Sciences* 165. See also Tomas Hemmingsson and Ingvar Lundberg, 'Development of alcoholism: interaction between heavy adolescent drinking and later low sense of control over work' (2001) 36 *Alcohol and Alcoholism* 207.

²² Joan McCord, 'Family Relationships, Juvenile Delinquency, and Adult Criminality' (1991) 29 *Criminology* 397.

²³ Ronald L Simons *et al.*, 'Parenting Factors, Social Skills, and Value Commitments as Precursors to School Failure, Involvement with Deviant Peers, and Delinquent Behavior' (1991) 20 *Journal of Youth and Adolescence* 645.

²⁴ *Ibid.*

²⁵ Stewart, Dennison and Waterson, above n 20.

²⁶ Dante Cicchetti and Donald J Cohen (eds), *Developmental Psychopathology* (John Wiley New York, 2nd ed, 2006).

²⁷ *Ibid.*

²⁸ Susan Zuravin *et al.*, 'The Intergenerational Cycle Of Child Maltreatment Continuity Versus Discontinuity' (1996) 11 *Journal Of Interpersonal Violence* 315.

²⁹ Dante Cicchetti and Donald J Cohen (eds), *Developmental Psychopathology* (John Wiley New York, 2nd ed, 2006).

³⁰ Kieran P O'Hagan, 'Emotional and psychological abuse: Problems of definition' (1995) 19 *Child Abuse & Neglect* 449.

³¹ Adam M Tomison and Joe Tucci, 'Emotional Abuse: the hidden form of maltreatment' (Issues in Child Abuse Prevention No 8, National Child Protection Clearinghouse, 1997).

emotional harm, recommend that the abuse should go legally unreported.³² In cases where the parent has a mental illness, there is a strong counter-expectation that the state should intervene, with the corollary that the parent's parental rights will be limited or terminated by legal proscription.³³ Imperfect parenting from a parent experiencing a mental illness is publically and professionally less tolerated than the imperfect parenting by parents without a mental illness diagnosis.

2.1 The good v the bad parent

As a coping mechanism for the 'anxieties engendered by our inability to control the world',³⁴ Gilman claims that a Manichean perception of the world being divided into the 'good' or the 'bad' produced a universal need for stereotypes to create illusions of absolute difference between the 'us and them'.³⁵ The 'good parent', or arguably, the far more prevalent 'good enough parent',³⁶ is a rather nebulous being that possesses a conglomeration of qualities drawn from a group of acceptable attributes. The concept recognises that it is both unrealistic and unhelpful to demand perfection from parents as doing so undermines the majority of parents, who for all practical purposes, are 'good enough' to satisfy their children's needs.³⁷ Qualities such as responsibility, kindness and understanding, industriousness, stability of personality, faithfulness, loyalty and benevolent discipline are variously grouped into different parenting styles which set and enforce a child's boundaries, promote their emotional and physical health, optimise their potential, and maximise their opportunities for realising that potential.³⁸

There is, however, a lack of a research-based, empirically driven definition for what constitutes acceptable minimal parenting capacity. The parameters of 'good enough' parenting have been socially constructed from subjective impressions,

³² Stephanie Hamarman and William Bernet, 'Evaluating and Reporting Emotional Abuse in Children: Parent-Based, Action-Based Focus Aids in Clinical Decision-Making' (2000) 39 *Journal of the American Academy of Child and Adolescent Psychiatry* 928.

³³ Laura J Miller and Molly Finnerty, 'Sexuality, pregnancy, and childrearing among women with schizophrenia-spectrum disorders' (1996) 47 *Psychiatric Services* 502.

³⁴ Sander L Gilman, *Difference and pathology: stereotypes of sexuality, race, and madness* (Ithaca: Cornell University Press, 1985) 12.

³⁵ *Ibid.*, 18.

³⁶ Masud Houghugh and ANP Speight, 'Good Enough Parenting For All Children—A Strategy for a Healthier Society' (1998) 78 *Archives of Disease In Childhood* 293.

³⁷ *Ibid.*

³⁸ *Ibid.*

culture bound beliefs and context related thresholds of concern.³⁹ This raises the question of how parenting risks should be weighed against parenting strengths, or how the theoretical concept of a child's best interests is applied to the complex and dynamic circumstances of each individual case.⁴⁰ Even the principle of 'best interests of the child' discussed at Section 3.2 below is considered too vague. It fails to offer the decision-maker clearly defined boundaries in the sense that the parents, legal representatives and expert witnesses all prescribe to be acting in the child's best interests when presenting the court with conflicting alternatives.⁴¹

Although social science research has provided courts with some general guidance, it has not advanced to the level of validating any specific behavioural indicators or standards of childrearing adequacy that can be applied to individual cases.⁴² Courts generally rely on the presumption that as long as the development and behaviours of the child are positive, the parental care is 'good', and until the time the child exhibits inappropriate or unacceptable behaviours, or publically declares their parent's abuse or neglect of them,⁴³ their parental care is accepted as good, unless of course, the parent has a mental illness. In this situation, the reverse assumption appears to apply.

As was discussed in Chapter Three, the difference associated with mental illness is perceived as bad.⁴⁴ Invariably, the stereotypes, prejudices and discriminations generated by ignorance, fear, and the assumptions that people with a mental illness are unable to organise their lives within a framework of consistent normalcy; are

³⁹ Peter Reder, Sylvia Duncan and Clare Lucey (eds), *Studies in the assessment of parenting* (Hove, Brunner-Routledge, 2003).

⁴⁰ Lois Oberland Condie, *Parenting evaluations for the court: Care and protection matters* (Kluwer Academic/Plenum, 2003). See also Karen S Budd, 'Assessing parenting capacity in a child welfare context' (2005) 27 *Children and Youth Services Review* 429.

⁴¹ Ibid. See also Karen S Budd, 'Assessing parenting capacity in a child welfare context' (2005) 27 *Children and Youth Services Review* 429.

⁴² Karen S Budd and Rachael E Springman, 'Empirical Analysis of Referral Issues And "Ultimate Issue" Recommendations For Parents In Child Protection Cases' (2011) 49 *Family Court Review* 34.

⁴³ In 1978, the adopted daughter of the film star Joan Crawford wrote one of the first 'tell all' books in which she claimed that she was a victim of child abuse. Christina Crawford, *Mommie Dearest* (W. Morrow, 1978). Joan Crawford up until 1978 had been cast in the role of 'good parent' having had adopted and cared for four children. The title of the book has been instilled into popular language as a descriptor for a 'bad' mother. In 2011, actress Jacki Weaver was nominated for an Academy Award for playing the bad mother in the film Australian film *Animal Kingdom*. When Matt Mazur interviewed Weaver for Pop Matters Magazine, 13 August 2010, he titled the article, *Mommie Dearest: An Interview with Animal Kingdom's Jacki Weaver*. See Matt Mazur, 'Mommie Dearest: An Interview with Animal Kingdom's Jacki Weaver' *PopMatters* (online), 13 August 2010 <<http://www.popmatters.com/pm/feature/129328-mommie-dearest-an-interview-with-animal-kingdoms-jacki-weaver/>>.

⁴⁴ Patrick W Corrigan and Amy C Watson, 'Understanding the impact of stigma on people with mental illness' (2002) 1 *World Psychiatry* 16, 16.

incapable of controlling their disordered, impulsive and maladaptive thoughts, or restraining their emotional disturbances; and lack the capacity to maintain functional relationships,⁴⁵ stamp them as a ‘bad parent’. They are deficient in their parenting skills. And while there may be no evidence that they are harming their child in the present, the potential that they might do so at some point in the future is considered by courts to a risk that is unacceptable. This issue is discussed in more depth in Section 5.0 below.

3. PARENTING RESEARCH

The predominant practice prior to the process of deinstitutionalisation was the, often long term, confinement of people to mental asylums which ultimately, denied them the opportunity to parent children.⁴⁶ The current public concern regarding the maltreating, neglectful, absorbed, cold and distant parent who is experiencing a mental illness is a relatively new social issue. It arose globally in response to community care and treatment policies⁴⁷ that have raised the public’s concern that the insufficiencies of community services⁴⁸ have left people to ‘fall through the cracks’.⁴⁹ This has led some commentators to declare that community care is a failed initiative.⁵⁰ However, living outside institutionalised care has provided more opportunities for planned, and unplanned, parenthood⁵¹ and has resulted in a great increase of children, and their parents, coming before child protection and family law decision-makers.

⁴⁵ Nicolas Rüsch, Matthias C Angermeyer and Patrick W Corrigan, ‘Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma’ (2005) 20 *European Psychiatry* 529, 530.

⁴⁶ Kathleen Coulborn Faller and Chyrell D Bellamy, ‘Mental health problems and child maltreatment’ (1999) <<http://141.211.91.162/public/currentProjects/icwtp/mentalhealth/d-mhpar.pdf>>.

⁴⁷ Alan Rosen, Liz Newton and Karen Barfoot, ‘Clinical Perspectives: Evidence based Community Alternatives to Institutional Psychiatric Care’ (2003) 4 *Medicine Today* 90.

⁴⁸ Rachel Merton and Jenna Bateman, ‘Social Inclusion: Its importance to Mental Health’ (Research Paper, Mental Health Coordinating Council Inc., June 2007) <<http://www.mhcc.org.au/images/uploaded/MHCC%20Social%20Inclusion%20booklet.pdf>>

⁴⁹ Coulborn Faller and Bellamy, above n 46, 1.

⁵⁰ Julian Leff, ‘Why is care in the community perceived as a failure?’ (2001) 179 *The British Journal of Psychiatry* 381.

⁵¹ Coulborn Faller and Bellamy, above n 46, 1.

3.1 The adversity approach

While the documenting of negatively affective parental behaviours of parents who have a mental illness, particularly mothers,⁵² is well established in the social science literature,^{53 54} the focus of the research has been on the possible detrimental effects to the child. The tendency of the affluence of mainly social work literature has been to present the parent as permanently flawed and inherently incapable of fulfilling a proper parenting role.⁵⁵ Parents are classified as less emotionally available, less reciprocal, less involved, less affectionate, less responsive, less encouraging and less positive⁵⁶ and their children more likely to exhibit general difficulties in functioning, increased guilt, interpersonal difficulties, problems with attachment, marital difficulties and parenting problems.⁵⁷ If required to spend a considerable amount of time with the parent, the child is believed to feel less stable.⁵⁸ There is also an assumption that parents who exhibit extreme behaviours in their child's presence make their child vulnerable and at-risk of developing their own mental health problems.⁵⁹

Children are deemed to be adversely affected their parent's mental illness; directly by neglect, physical harm, and/or psychological upset, or indirectly as a consequence of the associated factors of mental illness including poverty,⁶⁰ repeated

⁵² Joanna Nicholson, Elaine Sweeney and Jeffrey Geller, 'Focus on Women: Mothers with Mental Illness: I. The Competing Demands of Parenting and Living with Mental Illness' (1998) 49 *Psychiatric Services* 635. See also Laura J Miller and Molly Finnerty, 'Sexuality, pregnancy, and childrearing among women with schizophrenia-spectrum disorders' (1996) 4 *Psychiatric Services* 502; R Kumar *et al.*, 'Clinical survey of a psychiatric mother and baby unit: characteristics of 100 consecutive admissions' (1995) 33 *Journal of Affective Disorders* 11; Jill G Joseph *et al.*, 'Characteristics and Perceived Needs of Mothers with Serious Mental Illness' (1999) 50 *Psychiatric Services* 1357.

⁵³ Joanna Nicholson, Elaine Sweeney and Jeffrey Geller, 'Focus on Women: Mothers with Mental Illness: I. The Competing Demands of Parenting and Living with Mental Illness' (1998) 49 *Psychiatric Services* 635.

⁵⁴ Clara Hemphill, 'Hard Choices: Caring for the children of mentally ill patients' (2009) 17 *Child Welfare Watch* 1.

⁵⁵ Barry J Ackerson, 'Coping with the dual demands of severe mental illness and parenting: the parent's perspective' (2003) 84 *Families in Society: The Journal of Contemporary Human Services* 109.

⁵⁶ Carol Mowbray *et al.*, 'Parenting of mothers with a serious mental illness: differential effects of diagnosis, clinical history, and other mental health variables' (2002) 26 *Social Work Research* 225.

⁵⁷ William R Beardseele, Eve M Versage and Tracy R G Giadstone, 'Children of Affectively Ill Parents: A Review of the Past 10 Years' (1998) 37 *Journal of the American Academy of Child & Adolescent Psychiatry* 1134.

⁵⁸ Marc J Ackerman, *Clinician's Guide to Child Custody Evaluations* (John Wiley & Sons, 3rd ed, 2006) 190.

⁵⁹ David C Factor and David A Wolfe, 'Chapter 7 Parental Psychopathology and High-Risk Children' in Robert Ammerman and Michel Hersen (eds), *Children at Risk: An Evaluation of Factors Contributing to Child Abuse and Neglect* (New York: Plenum Press, 1990) 172.

⁶⁰ Knutson, DeGarmo and Reid, above n 18. According to the third National Incidence Study (NIS-3) of child maltreatment in the U.S., physical abuse was associated with economic disadvantage and children from households with annual incomes less than \$15K were almost 16 times as likely to be considered physically abused when the harm standard was used and 12 times more likely to be considered physically abused when the endangerment standard was used, than those from households with incomes greater than \$30K.

hospital admissions, and marital disharmony.⁶¹ They are at heightened risk of developing mental health problems as they get older, perinatal complications and other health problems in infancy, social and behavioural problems in childhood and adolescence, and the consequences of stress associated with caring for a mentally ill parent.⁶² A child who has a parent with mental illness faces an adversity that is said to threaten their basic desire for safety and biological integrity; sense of personal control; social relatedness; self worth and attainment of developmental competencies.⁶³

3.2 Countering the adversity approach

The adversity research approach does have its critics. Mordoch and Hall concluded from their review of the literature that researchers ignored the child's perspective, focusing instead on factors considered as affecting the children's pathology.⁶⁴ Investigators had defined pathology from a narrow biomedical focus that 'reflected their own normative judgments expressed through the use of restrictive diagnostic categories and behavioral measures'.⁶⁵ Biomedical terms such as 'unrecognised and protracted grief', 'psychic loss' and 'chronic sorrow' are claims attributed to children living with parents with a mental illness but do not have the necessary evidence and explanation as to how those feelings operate in the children's lives.⁶⁶ They suggest that although marital discord is implicated in poor mental health outcomes for children, studies of children's perspectives about parental dynamics in families where a parent has a mental illness needs to occur.⁶⁷

Ackerson's review of the research found that the researchers tended to focus on the parent's pathology, and the potential risks for their children, without considering the parent's perspective.⁶⁸ He noted that the literature failed to discuss the strengths that many parents bring to managing their illness while caring for their children.

⁶¹ Louis Appleby and Chris Dickens, 'Mothering skills of women with mental illness' (1993) 306 *British Medical Journal* 348.

⁶² Ibid.

⁶³ Irwin Sandler, 'Quality and ecology of adversity as common mechanisms of risk and resilience' (2001) 1 *American Journal of Community Psychology* 19.

⁶⁴ Elaine Mordoch and Wendy A Hall, 'Children living with a parent who has a mental illness: A critical analysis of the literature and research implications, literature and research implications' (2002) 16 *Archives of Psychiatric Nursing* 208.

⁶⁵ Ibid.

⁶⁶ Ibid.

⁶⁷ Ibid.

⁶⁸ Ackerson, above n 55.

Parenthood, as a typical and normal role, plays a critical role in a person's conceptualisations of self and identity⁶⁹ and parenting provides value, meaning and security in the life of a mother with a mental illness.⁷⁰ Mothers with a serious mental illness described their efforts to have meaningful relationships with their children as providing them with a sense of being normal, secure and responsible⁷¹ and strongly believed that the biomedical entity did little to represent their mothering realities.⁷² Ackerson also suggested that parenting might not cause the stress or demands commonly feared to negatively affect parent outcomes or psychiatric symptoms.⁷³

Mullick found that, as it is in society generally, 'Parents within any given diagnostic category can have parenting skills ranging from excellent to maltreating'⁷⁴ but that researchers focused on the 'maltreatment' end of the scale and made little effort to show the potential parenting capabilities of parents whose mental illness is properly managed.⁷⁵ Despite the temporary inability to parent during periods of incapacity, with the proper supports, parents with a severe mental illness still have much to offer.⁷⁶ Although there is an abundance of studies supporting a negative relationship between a parent's mental illness and their child's well-being, no definite causal relationships can be drawn from the available research as little is known about the extent to which illness circumstances predict childhood problems. The findings must be interpreted with caution.⁷⁷

The present negative social scientific attitude toward the parenting abilities of people with a mental illness challenges courts to decide whether there can ever be sufficient benefit to the child, no matter what interpretation is given to statutory

⁶⁹ Jennifer P Wisdom *et al.*, 'Stealing me from myself': identity and recovery in personal accounts of mental illness' (2008) 42 *Australian & New Zealand Journal of Psychiatry* 489. See also Priscilla K Coleman and Katherine H. Karraker, 'Self-efficacy and parenting quality: Findings and future applications' (1998) 18 *Developmental Review* 47. Coleman and Karraker suggest that labeling a parent as a 'bad parent' can cause depression.

⁷⁰ Mordoch and Hall, above n 64.

⁷¹ Phyllis Montgomery *et al.*, 'Keeping close: mothering with serious mental illness' (2006) 54 *Journal of Advanced Nursing* 20.

⁷² *Ibid.*

⁷³ Ackerson, above n 55.

⁷⁴ Mrinal Mullick, Laura J Miller and Teresa Jacobsen, 'Insight into mental illness and child maltreatment risk among mothers with major psychiatric disorders' (2001) 52 *Psychiatric Services* 488, 489.

⁷⁵ Robert M Galatzer-Levy, Louis Kraus and Jeanne Galatzer-Levy, *The Scientific Basis of Child Custody Decisions* (John Wiley & Sons, 2009).

⁷⁶ *Ibid.*

⁷⁷ Montgomery *et al.*, above n 71, 21.

requirements such as ‘meaningful relationship with a parent’.⁷⁸ Even if a court decides that there is a benefit, in its mind the child continues to remain vulnerable to possible and potential future harms and risks ranging from being murdered to not achieving their ‘full potential’.⁷⁹ ‘In many cases it is often argued that a parent’s mental illness gives rise to an unacceptable risk to the child’.⁸⁰

3.3 The courts’ use of social science research in parenting decisions

Although an overall discussion of judicial decision-making was undertaken in Chapter Five, this section briefly examines the use of social science research in parenting matters. Judges are guided considerably by their subjective judgment as to whether a necessary criterion has been met in any given instance. In matters in which a parent deviates from the ‘norm’, the degree of subjectivity used by the judge frequently escalates.⁸¹ The ‘fear or loathing’ that the judge may feel toward mental illness may cause them to ‘obviously or artfully, disregard the statutory or common law standards and to avoid even the pretext of a genuine attempt to discover how the interests of the child might be served.’⁸² Browne and Giampetro suggest that judges often make parenting decisions that are in harmony with social science findings although it is not necessarily the case that they have deferred to the findings, but that the findings are simply consistent with the common sense hunches that judges use in discretionary decision-making.⁸³ The judicial value of social science data in parenting matters in which parental mental illness is a factor generally rests in its support of achieving the outcome the judge desires.⁸⁴

In a society in which rationality is considered the measure of competence generally, and parental ability specifically,⁸⁵ it is presumed that a person who has a mental illness is an inadequate parent. This stereotypical presumption is well established in

⁷⁸ *Family Law Act 1975* (Cth) s 60CC(2)(a).

⁷⁹ *Ibid* (2)(b).

⁸⁰ Ryan, above n 5.

⁸¹ Anne T Payne, ‘The Law and the Problem Parent: Custody and Parental Rights of Homosexual, Mentally Retarded, Mentally Ill and Incarcerated Parents’ (1977-1978) 16 *Journal of Family Law* 797.

⁸² *Ibid* 798.

⁸³ M Neil Browne and Andrea Giampetro, ‘The Contribution of Social Science Data to the Adjudication of Child Custody Disputes’ (1985-1986) 15 *Capital University Law Review* 43.

⁸⁴ *Ibid*.

⁸⁵ Robert L Hayman, ‘Presumptions of Justice: Law, Politics, and the Mentally Retarded Parent’ (1990) 103 *Harvard Law Review* 1201. While this article deals particularly with parents who have an intellectual disability, the author demonstrates that the same legislative presumptions and applications are applied to parents who have a mental illness. ‘The purpose of the statute is to protect and promote the welfare of the child. The legislature has considered the very real possibility that a mentally ill or retarded individual may be unable to handle the responsibility of a child.’ at n.204.

the legal system, sitting alongside other stereotypical presumptions such as people with a mental illness are not truthful, are manipulative, cannot make rational decisions and are likely to be violent. They are thought to have a reduced intellectual capacity and are commonly confused with people who have an intellectual disability^{86 87} which was a finding in the study of the attitudes of law students reported in Chapter Eight at Sections 5.6.3 and 5.6.4. Yet, there are studies that show that two-thirds of families with parental mental illness suffer no long-term behavioural or emotional difficulties,⁸⁸ that many parents regard their bond with their children as very strong and close;⁸⁹ and that the negative effects of serious mental illness can be offset with adequate supports that enable the parent to successfully care for their children.⁹⁰

Although most social science studies have extremely small samples and tend to focus on specific high profile groups, the results are applied within the breadth of their judicial discretion generally by judges who seek to use the data to justify what they intend to do.⁹¹

4. THE FAMILY LAW ACT 1975 - PART VII AMENDMENTS AND THE PARENT WITH A MENTAL ILLNESS

The *Family Law Act 1975* (the Act) is the major of piece of legislation governing the operation of family law in Australia. The relevant Part VII provisions applied to the court's decisions about with whom a child is to live, and who they will spend time with have gradually become more prescriptive since the Act's enactment in 1975. Part VII was significantly amended in 1995, again in 2006, and then again in June 2012 with the Family Law Legislation Amendment (Family Violence and Other Measures) Act 2011.

⁸⁶ Richard Evans, 'Seeking Justice for the Mentally Ill' (1995) 69 *Law Institute Journal* 642.

⁸⁷ The results of the study of the attitudes of law students undertaken as part of this thesis confirmed that there is confusion between mental illness and intellectual disability in the community.

⁸⁸ Michael Rutter and David Quinton, 'Parental psychiatric disorder; effects on children' (1984) 14 *Psychological Medicine* 853.

⁸⁹ Ackerson, above n 55.

⁹⁰ Andrea Reupert and Darryl Maybery, 'Families affected by parental mental illness; A multiperspective account of issues and interventions' (2007) 77 *American Journal of Orthopsychiatry* 362.

⁹¹ Browne and Giampetro, above n 83.

The 2012 amendments were the government's response to the increasing public concern about family violence and abuse. They were intended to remove disincentives to disclosing family violence to the courts, update the definitions of family violence and child abuse so as to clearly set out unacceptable behaviour such as physical and emotional abuse, and the exposure of children to family violence, and to ensure that appropriate action is taken to prioritise the safety of children in family law disputes. The intention of the reforms was to put the safety of children foremost in family law matters without compromising the child's right to a meaningful relationship with both parents in situations in which it is safe.⁹² Courts applying the objective 'best interests' test were required to address two tiers of consideration; (1) primary considerations⁹³ and (2) additional considerations,⁹⁴ giving the greater weight to the s.2 (b) consideration, 'the need to protect the child from physical or psychological harm and from being subjected to, or exposed to, abuse, neglect or family violence'.⁹⁵

4.1 Parenting Orders

The role of the family court is to assess effective parenting capacity, modify poor parenting behaviours, and if necessary, limit or terminate the parent's association with their child. It must also consider any other fact or circumstance it thinks relevant,⁹⁶ a consideration that captures the allegation of a parent's mental illness. When examining a parent's parenthood responsibilities,⁹⁷ the court must consider the extent to which a parent has taken, or failed to take, the opportunity to participate in making decisions about major long-term issues and has communicated with, and spent time with the child.⁹⁸ The parent experiencing a mental illness may not measure well against this normative measure as their symptoms and medications can often supersede desire, intention and direction. The stigma associated with mental illness suggests that the parent is unable to provide adequate and proper parenting due to a lack of capacity to interact with their child in a meaningful or safe way: a primary consideration requirement in the Act.

⁹² Australian Family Law Courts website

<http://www.familylawcourts.gov.au/wps/wcm/connect/FLC/Home/Whats+New/FLC_family_law_changes>.

⁹³ *Family Law Act* 1975, s.60CC (2).

⁹⁴ *Ibid* (3).

⁹⁵ *Ibid* 2A.

⁹⁶ *Ibid* (3)(m).

⁹⁷ *Ibid* (3)(i).

⁹⁸ *Ibid* (4).

Prior to the *Family Law Reform Act* 1995 amendments, courts had to give ‘regard the welfare of the child as the paramount consideration’.⁹⁹ This was replaced by the ‘best interests of the child’,¹⁰⁰ which had replaced the long standing common law ‘tender years’ doctrine. Family law courts were no longer able to overtly apply the doctrine to their decision-making although recent U.S. statistics that indicate that 82.2% of children of divorced families live with their mothers¹⁰¹ suggest that courts do still demonstrate a preference to placing children into the daily care of their mother unless there are compelling reasons why this should not occur. As is discussed below at Section 5.0, a compelling reason is often the perceived unacceptability of the risk that is associated with having a mental illness.

The Family Law Amendment (Shared Parental Responsibility) Act 2006 (SPR) amendments introduced the term ‘meaningful’ into the Act with section 60B(1) referring to ‘the benefit of both of their parents having a meaningful involvement in their lives’ and s.60CC(2) making note of ‘the benefit to the child of having a meaningful relationship with both parents’. In litigated circumstances of marital separation involving children of the relationship, the court is required to make a parenting order.¹⁰² There is a presumption that it is in the best interests of the child for parental responsibility to be equally shared by both parents¹⁰³ although the presumption can be rebutted if it is shown that there is some undesirable aspect to one of the parent’s lifestyles.¹⁰⁴

Mental illness is often raised as a negative and/or disqualifying factor sufficient to rebut the presumption.¹⁰⁵ When raised, courts will often reorient the proceedings to make the central question the parent’s mental health diagnosis¹⁰⁶ because the diagnostic label stamps them as the least credible person in the process. Fear and risk, the immutable associates of a psychiatric diagnosis that can weigh heavily on the mind of a court challenged under the Act to decide whether there can ever be sufficient benefit to the child in having a relationship with a parent who has a

⁹⁹ Previous s.64(1)(a) of the *Family Law Act* 1975.

¹⁰⁰ *Family Law Act* 1975, s.60CA

¹⁰¹ Timothy S Grall, ‘Custodial Mothers and Fathers and Their Child Support: 2009’ (Current Population Reports No P60-240, U.S. Department of Commerce Economics and Statistics Administration United States Census Bureau, December 2011) <<http://www.census.gov/prod/2011pubs/p60-240.pdf>>.

¹⁰² *Family Law Act* 1975, s.64B

¹⁰³ *Ibid* 61DA.

¹⁰⁴ *Ibid* 61DA(4).

¹⁰⁵ Ryan, above n 5.

¹⁰⁶ Judith Mosoff, ‘Motherhood, Madness, and Law’ (1995) 45 *The University of Toronto Law Journal* 107.

mental illness when the decision-maker maintains the belief that if they decide yes, the child may be left vulnerable within an environment of potential harms and risks that are associated with mental illness.¹⁰⁷

4.2 The ‘best interests of the child’

The concept of ‘best interests’ is a guiding standard, whereby, in any given circumstance, reasonable people make reasonable decisions based on reasonable principles and the balancing and weighting of facts. The test has been criticised in the legal literature as being overly vague and that it leaves too much to the discretion of the judge so as to be little better than no legal standard at all.¹⁰⁸ When a judge applies an objective test to whether it is in the best interests of a child to live with their mother or their father, both of whom are loving, caring, responsible parents, the decision will be subjective. It is dependent on the weight the judge gives to each of the legal elements, and the weight given to each set of specific circumstances that are unique to each of the stakeholders involved in the court’s decision. The weight given to each factor reflects the judge’s own priority values and principles, an issue that was discussed in Chapter Five.

Although the Act specifies a list of considerations the court must give its thought to when reaching a best interests decision, the list is not limited and the court is encouraged to consider anything characteristic to the child or their parents that is relevant to the well-being of the child.¹⁰⁹ The almost universally adopted ‘best interests of the child’ test¹¹⁰ ‘encourages the court to focus upon the unique needs of a particular child and his or her parents’ comparative capabilities for meeting those ends’.¹¹¹ It considers not only the practical and tangible influences, but also

¹⁰⁷ *Family Law Act* 1975, s.60CC (2)(b).

¹⁰⁸ Robert E Emery, Randy K Otto and William T O’Donohue, ‘A Critical Assessment of Child Custody Evaluations Limited Science and a Flawed System’ (2005) 6 *Psychological Science in the Public Interest* 1. See also Robert H Mnookin, ‘Child custody adjudication: Judicial functions in the face of indeterminacy’ (1975) 39 *Law and Contemporary Problems* 226.

¹⁰⁹ *Family Law Act* 1975, s.60CC(3)(g).

¹¹⁰ *Convention on the Rights of the Child* art 3(1) states that ‘1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.’

¹¹¹ Warren T. Reich (editor in chief) *Encyclopedia of Bioethics*, Revised Edition, Simon & Schuster MacMillan, 1995, Lucy S McGough, ‘Children/V. Child custody’, 371, 373.

the emotional and psychological influences that impact on the child's world.¹¹² It is predictive.

While many commentators support the 'best interests of the child' principle for its responsiveness to the unusual and different circumstance of individual children and their families, others, accepting that individualised decision making is appealing on the surface, express concern that broad and differing interpretations of the vague concept result in unpredictability in judicial decision-making and furtherance of litigation,¹¹³ and that this 'allows for bias to intrude in the exercise of judicial discretion'.¹¹⁴

Although legislation may provide some guidance on how a best interest decision should be made, it is left to the court to define that which may well be indefinable. The High Court in *Marion's case*¹¹⁵ believed it was impossible to formulate a precise test capable of answering the question of 'best interests'.¹¹⁶ Justice Brennan noted the limited usefulness of 'best interests' stating that it 'does no more than identify the person whose interests are in question, it does not assist in identifying the factors which are relevant to the best interest of the child'.¹¹⁷ Courts have also raised their concerns regarding the arbitrary exercise of best interest decision-making with judges feeling that because they are forced to make their decision by balancing all the considerations, it is impossible to give a uniquely right answer.¹¹⁸ The consequence of this balancing act is that judges substitute their own principles and standards to reach a decision that satisfies them as to the rightness of the decision but hauntingly, leaves open the question of whether it is truly the right decision for the child.

In *Burke & Van Der Molen*,¹¹⁹ the mother had a history of paranoid schizophrenia and had previously been in a long relationship characterised by domestic violence. The pivotal issues for the court were the capacity of the mother to care for her

¹¹² Loretta M Kopelman, 'The Best-Interests Standard as Threshold, Ideal, and Standard of Reasonableness' (1997) 22 *The Journal of Medicine and Philosophy* 271, 273.

¹¹³ Castan Centre for Human Rights Law, Submission to the Family Law Council, The Inquiry Into Relocation Of Children In Family Law, April 2006.

¹¹⁴ Emery, Otto and O'Donohue, above n 108, 6.

¹¹⁵ *Marion's Case* (1992) 175 CLR 218.

¹¹⁶ *Ibid* 251.

¹¹⁷ *Ibid* 270.

¹¹⁸ Stephen Parker, Patrick Parkinson and Juliet M Behrens, *Australian Family Law in Context: Commentary and Materials* (LBC Information Services, 1999) 740.

¹¹⁹ *Burke & Van Der Molen* [2002] FMCA 276.

daughter by meeting her physical and emotional needs, and her capacity to protect the child from family violence.¹²⁰ The expert psychiatric witness provided evidence of the mother's compliance with treatment, her suitable accommodation, and recommended that 'Medically, I feel that [the mother] is at present in a stable situation and is capable of resuming care of her daughter'.¹²¹

But ultimately, it was the mother's mental illness and the unacceptable risk that it represented that gave cause for Ryan FM to base his parenting order decision on the fact that the father did not have a mental illness in contrast to the mother who did. 'In [the father's] care by comparison to [the mother's] care, she lives with a parent who does not have a serious mental illness ... [t]here are not the risks inherent in [the girl's] care if she lives with her father as there are if she lives with her mother.'¹²²

4.3 Meaningful relationship

Section 60B(1) of the *Family Law Act* 1975 refers to 'the benefit of both of parents having a meaningful involvement in their lives' while s.60CC(2) notes 'the benefit to the child of having a meaningful relationship with both of the child's parents'. Unfortunately, what constitutes a 'meaningful relationship' or 'meaningful involvement' is not clear because 'meaningful' is not defined in the Act.¹²³ 'Nor does the Act provide any specific criteria to assess how parents either have, or should have, a 'meaningful involvement' in a child's life or give guidance to the interpretation of the phrase 'meaningful relationship.'¹²⁴ Yet, for the few academic commentators who have thus far discussed the reform, the concept of 'meaningful'

¹²⁰ Ibid, 47.

¹²¹ Ibid.

¹²² Ibid, 53

¹²³ *McCall & Clark* [2009] FamCAFC 92, [109].

¹²⁴ Ibid.

is an intuitively attractive notion¹²⁵ that is primarily about parental attunement and the emotional security that it brings.¹²⁶

The conceptual vagueness of the SPR amendments helped in making the task of determining what is in the best interest of the child even more complex.¹²⁷ A dictionary interpretation of 'meaningful' relationship is one that has meaning, function, or purpose raising the question of whether a relationship classified as 'meaningful' must be a current relationship or whether a presently non-meaningful relationship has the potential for becoming meaningful in the future. Moloney suggested that when making judgements about meaningfulness, courts needed to consider the ultimate purpose of the meaningful relationship and whether the relationship was meant to be meaningful in its own right or whether it had a wider purpose such as helping the child to achieve and develop a sense of identity. Was a 'meaningful relationship' composed of specific elements (some of its parts) or was it the overall experience (the sum of its parts)?¹²⁸

The vagueness of 'meaningful relationship' has resulted in various constructions being given to the term by family law judges over the years. Justice Brown in *Mazorski v Albright* defined it as a qualitative adjective rather than a strictly quantitative concept,¹²⁹ describing the relationship as one that was 'important, significant and valuable to the child',¹³⁰ emphasising that the relationship's importance was from the child's perspective.¹³¹ Justice Murphy disagreed in *Runcorn & Raine*. He preferred the benefit approach stating that 'the Act does not require a court to consider whether a party's proposal is important, significant and

¹²⁵ Richard Chisholm, 'The meanings of 'meaningful' within the Family Law Act amendments of 2006: A legal perspective' (2009) 15 *Journal of Family Studies* 60. See also Richard Chisholm, 'Shared care and children's best interests: Working with the amendments of 2006' (Paper, Legal Aid NSW Family Law Conference, Sydney, 22 August, 2008). See also Richard Chisholm, 'Making it work: the Family Law Amendment (Shared Parental Responsibility) Act 2006' (2007) 21 *Australian Journal of Family Law* 143. Also Liz Trinder, 'What might children mean by a 'meaningful relationship'?' (2009) 15 *Journal of Family Studies* 20. Also Lawrie Moloney, 'Meaningful relationships' in the Family Law Act Amendments of 2006: A socio-legal perspective on fathers, mothers and the 'sharing' of parenting after separation' (2009) 15 *Journal of Family Studies* 9.

¹²⁶ Lawrie Moloney, 'Meaningful relationships' in the Family Law Act Amendments of 2006: A socio-legal perspective on fathers, mothers and the 'sharing' of parenting after separation' (2009) 15 *Journal of Family Studies* 9, 9.

¹²⁷ Daryl Higgins and Rae Kaspiew, 'Child protection and the family law...Joining the dots' (Research Paper No 34, National Child Protection Clearinghouse, 2011) <<http://www.aifs.gov.au/nch/pubs/issues/issues34/issues34.pdf>>.

¹²⁸ Moloney, above n 126.

¹²⁹ This was confirmed in *McCall & Clark* [2009] FamCAFC 92.

¹³⁰ *Mazorski & Albright* (2007) 37 Fam LR 518 [526] (Brown J).

¹³¹ Ibid 536.

valuable to a child. Rather, it appears to require the court to consider that such a relationship is of benefit to the subject children.¹³²

In *Godfrey and Sanders*, Justice Kay thought the term to be ‘an aspiration for a meaningful relationship, not an optimal relationship’.¹³³ A meaningful relationship was the most desirable relationship possible under the restrictions imposed by the facts. The Court found in *Champness & Hanson*¹³⁴ that a meaningful relationship could exist without a parent’s involvement in the daily lives of their children. This conflicted with Justice Murphy’s view in *Runcorn & Raine* that ‘quantity of time is an element of a meaningful relationship but not necessarily determinative of it.’¹³⁵

When Justice Cronin stated that ‘for there to be a meaningful relationship, it must be healthy, worthwhile and advantageous to the child’¹³⁶ he joined the normative standards of value and benefit with the biomedical concept of healthiness. The term ‘healthy’ is indicative of good physical or mental health and stresses the absence of disease. It is difficult to accept that a parent who has a mental illness could satisfy the court using this definition particularly as His Honour added that an assessment of the benefit to the child must be made according to ‘the peculiar facts of what the parents are offering.’¹³⁷ The unhealthy state of having a mental illness is a ‘peculiar fact’ that in many cases belongs exclusively to one parent, disadvantaging them against the parent without a mental illness.

The court in *Korban & Korban* in its examination of the term ‘consider’ in the context of 65DAA said:

The consideration of best interests involves an assessment of all the evidence presented and the making of factual findings. Some of those findings about one parent will demonstrate positive attributes which will benefit a child, other findings will highlight deficiencies or factors which are not likely to promote a child’s best interests.¹³⁸

¹³² *Runcorn & Raine* (2008) FamCA 837 [47] (Murphy J).

¹³³ *Godfrey and Sanders* (2007) 208 FLR 287 [36].

¹³⁴ *Champness & Hanson* [2009] FamCAFC 96.

¹³⁵ *Runcorn and Raine* (2008) FamCA 837 [45] (Murphy J).

¹³⁶ *Loddington & Derrington* (No 2) [2008] FamCA 925 [169].

¹³⁷ *Loddington & Derrington* (No 2) [2008] FamCA 925 [173].

¹³⁸ *Korban & Korban*, [2009] FamCAFC 143 [85].

The law clearly views a parent's mental illness as a clinical deficiency that is unlikely to promote the normative 'best interests of the child'. This picture of parental ineptitude is drawn from the law's reliance on what the biosocial sciences have to say about what constitutes good parenting and healthy, meaningful relationships which was discussed above at Section 3.4.

5. RISK ASSESSMENT

The discovery of child abuse by the medical profession occurred as a result of the early social scientists trying to understand the causes of parental maltreatment.¹³⁹ The researchers premised their research on the belief that only parents lacking some form of inner control; who were experiencing major thought psychopathy, or who were themselves victims of childhood trauma could be capable of behaving in such an abusive way. They assumed that a distinct psychiatric syndrome or disorder would be found that characterised parents or other caregivers who maltreated children.¹⁴⁰ Psychiatric factors were thought, probably, to be of 'prime importance in the pathogenesis of the disorder'.¹⁴¹ Inspired by this belief, they attempted, unsuccessfully, to map the role of parental psychopathology in child maltreatment cases.¹⁴²

There is a considerable amount of evidence to indicate that parents with mental illness are over-represented in cases of parental abuse of a child¹⁴³ and yet only 'a small proportion of maltreating parents could be diagnosed with a psychiatric condition and most individuals rarely displayed extreme psychopathology'.¹⁴⁴ The psychiatric-medical model of child abuse causation continues to fuel the stigma and prejudice associated with parenting by people who have, or are alleged to have, a

¹³⁹ Phillip Gillingham, 'Risk assessment in child protection: Problem rather than solution?' (2006) 59 *Australian Social Work* 86, 89.

¹⁴⁰ National Research Council, 'Understanding Child Abuse and Neglect' (Report, National Academy Press, 1993) 111.

¹⁴¹ C Henry Kempe *et al.*, 'The battered child syndrome' (1962) 181 *Journal of the American Medical Association* 17, 17.

¹⁴² Adam M Tomison, 'Child Maltreatment and Mental Disorder' (Discussion Paper No 3, National Child Protection Clearing House, 1996) <<http://www.aifs.gov.au/nch/pubs/discussionpaper/discussion3.html>>.

¹⁴³ Michael Sheppard, 'Double jeopardy: the link between child abuse and maternal depression in child and family social work' (1997) 2 *Child & Family Social Work* 91. See also Lawrence M Berger, 'Income, family characteristics, and physical violence toward children' (2005) 29 *Child Abuse & Neglect* 107. See also Leone Huntsman, 'Parents with mental health issues: Consequences for children and effectiveness of interventions designed to assist children and their families' (Literature review, Centre for Parenting & Research Service System Development Division New South Wales Department of Community Services, 2008) <http://www.community.nsw.gov.au/docswr/_assets/main/documents/research_parentalmentalhealth.pdf>.

¹⁴⁴ National Research Council, above n 140, 111.

mental illness even though the finding of a consistent profile of parental psychopathology or a significant level of mental disturbance is unsupported.¹⁴⁵ Researchers have relied largely on data drawn from retrospective studies of child protection cases in circumstances where an abuse has already occurred.^{146 147} Also, control groups were not used so it is not known whether the factors researchers identified were specific to the group.¹⁴⁸ Generally, study findings across the topic have been inconsistent and contradictory with the evidence cited for ‘principal risk factors’ for child abuse uncertain.¹⁴⁹

5.2 Assessing the risk

Decision-making surrounding allegations of child maltreatment intersect two different legal systems: child protection and family law. The differences in their approach to risk has led to the court system delivering harsher, and more unfair outcomes for parents with a mental illness, a claim that is discussed in more detail in the following sections. Some courts estimating risk use social-scientific risk assessment tools such as the family structure/severity of illness category system devised by Maybery *et al.*¹⁵⁰ The usefulness of these ‘at risk’ models and the application of ‘risk management’ - processes identification, assessment and prioritisation of risks - have become subject to recent criticism. The tools are claimed to be a statistical rather than psychological concept which Hubbard considers to be little better than astrology.¹⁵¹ Gillingham reports that in matters of child protection, the reliability of the assessment tools is extremely low and that the behaviour generalisations in the tools do not always apply. He notes that ‘Concepts

¹⁴⁵ Ibid.

¹⁴⁶ Gwynnyth Llewellyn, David McConnell and Luisa Ferronato, ‘Prevalence and Outcomes for Parents with Disabilities and their Children in an Australian Court Sample’ (2003) 27 *Child Abuse & Neglect* 235. This study funded by the Law and Justice Foundation of NSW examined the court files of all 285 care and protection matters (involving 469 children) initiated by the statutory child protection authority and finalized in a nine month period at two Children's Courts in NSW, Australia. Parental psychiatric disability was the most prevalent at 21.8% (84 cases)

¹⁴⁷ Rosemary Sheehan and Greg Levine, ‘Parents with mental illness: Decision-making in Australian Children’s Court cases involving parents with mental health problems’ (2005) 27 *Journal of Social Welfare and Family Law* 17. In this survey found that of the 114 cases referred to the Melbourne Children’s Court in early 2002 for pre-hearing conferences, 25% of the parents (28 parents) had mental health issues.

¹⁴⁸ Nigel Parton (ed), *Child Protection and Family Support: Tensions, Contradictions and Possibilities* (Routledge, 1997).

¹⁴⁹ Ibid.

¹⁵⁰ Darryl Maybery, Andrea Reupert and Melinda Goodyear, ‘Evaluation of a model of best practice for families who have a parent with a mental illness’ (Research Report, Charles Sturt University, 2006).

¹⁵¹ Douglas W Hubbard, *The Failure of Risk Management: Why It's Broken and How to Fix It* (John Wiley & Sons, 2009) 46.

such as risk of harm and actual harm are, in practice, used interchangeably'.¹⁵² This interchangeability aspect helps to reinforce the law's stereotypical conviction that parents who have a mental illness harm their children.

5.3 Risk thresholds in child protection

Risk to children is considered as measurable and manageable which implies that harm 'can always be effectively predicted and prevented - and that if it is not, then someone is to blame'.¹⁵³ Increased levels of public scrutiny and the community's concern over what it perceives to be poor child protection decisions¹⁵⁴ have resulted in risk-taking becoming strongly associated with blame, fear and aversion.¹⁵⁵ Much has been written nationally and internationally in past decades with regard to the perceived deficiencies of the child protection system.¹⁵⁶ Blame is often reflected in the negative media coverage, particularly when the story concerns the death of a child, of the child protection officer's 'wrong decisions' or the 'wrong procedures' that were in place in the child protection system.¹⁵⁷

Common system problems such as increasing case numbers, staff burnout and high staff turnovers have resulted in young and inexperienced staff conducting investigations and being required to make recommendations on complex cases^{158 159} that often intersect issues of domestic violence, mental illness and substance misuse.¹⁶⁰ Consequently, decision-making in child protection law has become highly risk averse.¹⁶¹ Some commentators suggest, however, that the acceptance and

¹⁵² Gillingham, above n 139, 88.

¹⁵³ Rhys Price-Robertson and Leah Bromfield, 'Risk assessment in child protection', Australian Institute of Family Studies, March 2011 <<http://www.aifs.gov.au/nch/pubs/sheets/rs24/>>. See Gillingham, above n 139.

¹⁵⁴ Higgins, above n 127.

¹⁵⁵ Ruth Gardner, 'Developing an effective response to neglect and emotional harm to children', University of East Anglia and The National Society for the Prevention of Cruelty to Children, January 2008, <http://www.nspcc.org.uk/inform/research/nspccresearch/completedresearch/DevelopingAnEffectiveResponseToNeglectPDF_wdf56700.pdf>.

¹⁵⁶ Justice James Wood, 'Report of the Special Commission of Inquiry into Child Protection Services in New South Wales' (Report, State of New South Wales; the Special Commission of Inquiry into Child Protection Services in New South Wales, 2008) <<http://www.dpc.nsw.gov.au/publications/news/stories/?a=33794>>.

¹⁵⁷ Marie Connolly and Mike Doolan, M, 'Child deaths and statutory services: Issues for child care and protection' (2007) 2 *Communities, Families and Children Australia* 26.

¹⁵⁸ Daryl Higgins and Ilan Katz, 'Enhancing service systems for protecting children: Promoting child wellbeing and child protection reform in Australia' (2008) 80 *Family Matters* 43.

¹⁵⁹ Australian Association of Social Workers (Qld) Submission to the Queensland Child Protection Commission of Inquiry, August 2012

<http://www.childprotectioninquiry.qld.gov.au/__data/assets/pdf_file/0007/161548/Healy_Karen.pdf>

¹⁶⁰ Leah Bromfield *et al.*, 'Issues for the safety and wellbeing of children in families with multiple and complex problems: The co-occurrence of domestic violence, parental substance misuse, and mental health problems' (Research Paper No 33, Australian Institute of Family Studies, National Child Protection Clearinghouse, December 2010).

¹⁶¹ Higgins, above n 127.

application of risk assessment tools has more to do with protecting the decision-maker and their authorities from blame and any mistakes that may have been made than trying to more effectively protect children.¹⁶²

5.4 The measure of harm in Australia's child protection legislation

Across Australia's child protection systems, the risk generally needs to be the significance of the harm: Queensland¹⁶³, Northern Territory¹⁶⁴, South Australian¹⁶⁵, Victorian¹⁶⁶, Western Australian¹⁶⁷ and Australian Capital Territory¹⁶⁸ Acts.

Recently, as a consequence of the Wood Inquiry into Child Protection in New South Wales,¹⁶⁹ the risk threshold in that state was raised to children needing care and protection only when they are at risk of 'significant harm'.¹⁷⁰

In Tasmania, in contrast to other Australian states and territories, the measure of the harm is missing altogether from the legislation. The Tasmanian *Children, Young Persons and Their Families Act* 1997, makes no reference to a child in need of care and protection but does refer to a child 'at risk'. This is the child who has been subjected to, is being subjected to or who is likely to be subjected to abusive and neglectful acts and behaviours; and who is subject to the consequences that arise from such acts and behaviours such as being physically or psychologically injured or harmed.¹⁷¹

5.5 Risk threshold in the family courts

The issue of 'risk to the child' has been discussed at length by Australian family law judges, most particularly, in regard to sexual abuse although 'ascertaining and giving appropriate weight to any situation which may represent future risk and the acceptability of such risk has a much wider application.'^{172 173} Fogarty offers examples of other situations which include 'the risk of serious violence, including

¹⁶² Gillingham, above n 139. See also Chris R Goddard, Bernadette J Saunders, Janet Stanley and Joe Tucci, 'Structured risk assessment procedures: Instruments of abuse? (1999) 8 *Child Abuse Review* 251.

¹⁶³ *Child Protection Act* 1999 (Qld) ss 9–10.

¹⁶⁴ *Care and Protection of Children Act* 2007 (NT) s 15(1).

¹⁶⁵ *Children's Protection Act* 1993 (SA) s 6(2).

¹⁶⁶ *Children, Youth and Families Act* 2005 (Vic) s 162.

¹⁶⁷ *Children and Community Services Act* 2004 (WA) ss 28 (1)–(2).

¹⁶⁸ *Children and Young People Act* 1999 (ACT) ss 151, 156.

¹⁶⁹ Wood, above n 156.

¹⁷⁰ *Children and Young Persons (Care and Protection) Act* 1998 (NSW) s 23.

¹⁷¹ *Children, Young Persons and Their Families Act* 1997 (Tas) ss 3, 4.

¹⁷² John Fogarty, 'Unacceptable risk - A return to basics' (2006) 20 *Australian Journal of Family Law* 249, 251.

¹⁷³ *A v A* (1998) FLC 92-800.

domestic violence, risks associated with a dysfunctional or hazardous lifestyle, or the imposition of social or religious attitudes which are seen to be outside broad community norms.¹⁷⁴ Although he does not mention mental illness specifically, ‘dysfunctional and hazardous lifestyle’ might be viewed as an encapsulation of such intent.

In *M and M*,¹⁷⁵ the High Court, when examining ‘risk’, indicated that a court must assess the magnitude of the risk. The efforts of courts to define with greater precision the magnitude of the risk has led to a number of different formulations. These include ‘risk of serious harm’¹⁷⁶; ‘an element of risk’ or ‘an appreciable risk’¹⁷⁷; ‘a real possibility’¹⁷⁸; a ‘real risk’¹⁷⁹; and an ‘unacceptable risk’.¹⁸⁰

The phrase ‘unacceptable risk’ was endorsed by the Full Court in *Johnson v Page*.¹⁸¹ It is this formulation that appears to be the current authoritative statement on the law¹⁸² although it raises the question of ‘unacceptable’ to whom and seems meaningless in the sense that it can be used by judges to mean whatever they want. It appears to be a cloak for discretion without much restraint. However, Fogarty suggests that the advantage of using this term is that ‘it is calibrated to the nature and degree of the risk, so that it can be adapted to the particular case’.¹⁸³ Yet when a court examines whether a parent’s mental health poses an ‘unacceptable risk’ to the child, the term ‘unacceptable risk’ is not always explicitly used.¹⁸⁴

Although the courts have tried to define with greater precision the magnitude of the risk associated with the harm, there is no absolute criteria on which judges can rely when deciding what constitutes ‘serious’ harm. The United Kingdom government’s

¹⁷⁴ Fogarty, above n 172, 251.

¹⁷⁵ *M and M* (1988) 166 CLR 69; 82 ALR 577; 12 Fam LR 606; [1988] FLC 91-979.

¹⁷⁶ *A v A* (1976) VR 298, [300].

¹⁷⁷ *Marriage of M* (1987) 11 Fam LR 765, [770]–[771].

¹⁷⁸ *B v B* (Access) (1986) FLC 91-758, [75] [545].

¹⁷⁹ *Leveque v Leveque* (1983) 54 B CLR 164, [167].

¹⁸⁰ *In re G* (a minor) (1987) 1 WLR 1461, [1469].

¹⁸¹ *Johnson and Page* [2007] Fam CA 1235; (2007) FLC 93-344 (May, Boland and Stevenson JJ) [68].

¹⁸² Richard Chisholm, ‘Unacceptable risk – a comparison of the family law and care jurisdictions’ (Article derived from a paper prepared for the Children’s Court Conference, Parramatta, 1 September 2010).

¹⁸³ Fogarty, above n 172, 252.

¹⁸⁴ Julia Beehag and Mitchell Little, ‘Family Consultant Mental Health Support Training – Case law on Unacceptable Risk and Mental Health’ (Research Memo, 12 February, 2008)

<https://docs.google.com/viewer?a=v&q=cache:9sZr_kTKjmQJ:www.fcms.net.au/documents/documents/Mental%2520Health%2520and%2520Unacceptable%2520Risk%2520Case%2520Law%2520Julia.doc+&hl=en&gl=au&pid=bl&srcid=ADGEEShtZ_4XYhbnpyBFd8eH0jfi5_OT0cMSHtOazYuALCStpnuTADsfW46cRgwPY5L4fXmacUd-QI4-sdHp8-2y0fQYQb1jQ4Z9LF9quaKSq6bdSLPClqIpKOWHZFxe6Qt5zJwsqInG&sig=AHIEtbRLHxX4TPgWZ9WDWnNVocvDGVBxbA>.

guidance to its courts is that parenting decisions are to be made by considering the maltreatment alongside the child's own assessment of his or her safety and welfare, the family's strengths and supports, as well as making an assessment of the likelihood and capacity for change and improvements in parenting and the care of children.¹⁸⁵ Conversely, the Australian courts' position is that the views of the child will not be given weight even if the child expresses a strong preference for the more dangerous placement.¹⁸⁶ Evidenced by the case studies presented in Section 6.0 below, the more dangerous placement appears to be the placement in which the parent has a mental illness.

5.6 Conflict between the two legal systems

The courts and child protection system's different approaches to risk have brought the two systems into conflict. The higher risk threshold of the child protection system means that it is not prepared to intervene in some matters for which the court holds the belief that it should. In *Ray and Males*, Benjamin J was critical of the Department of Children's Services (DOCS) and its unwillingness to intervene. He held that the Family Court had the power to make an order requiring DOCS to intervene.¹⁸⁷ The order was overturned on appeal to the Full Court which held that the Family Court does not have the power to order the intervention of the child protection system into a matter that is before the courts.¹⁸⁸

5.6.1 Case Study - *Michael and Ladders*¹⁸⁹

The complex case of *Michael and Ladders* is an example of the level of the conflict that exists between the child protection systems and the courts. In this case, the applicant mother sought the formalisation of existing contact arrangements (alternate weekends, half block holidays, weekly telephone calls), a mutual non-denigration order, and shared parental responsibility for the child whom she believed should continue to reside with her former partner. The mother was

¹⁸⁵ Department for Children Schools and Families, 'Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children' (Report, Department for Children Schools and Families, March 2010) 35
<www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/workingtogether/workingtogethertosafeguardchildren/>.

¹⁸⁶ *Franka and Grantham* [2011] FamCA 32 (1 February 2011) [33].

¹⁸⁷ *Ray and Males* [2009] Fam CA 219 (Benjamin J, 31 March 2009).

¹⁸⁸ *Secretary of the Department of Health and Human Services & Rollinson & Cheeseman & Ors* [2010] FamCAFC 258.

¹⁸⁹ *Michael and Ladders* [2008] FamCA 389.

diagnosed with schizophrenia. She had the delusion that her child was not her natural child. Due to the mother's psychiatric status and psychological condition, the father sought an order that the mother should only have one day a month supervised contact.

Justice Cohen felt that, as at times the mother had conducted her case without the benefit of legal representative, he had had ample opportunity to assess her. He decided that she was 'non-aggressive with very little, if any, animosity toward the father'.¹⁹⁰ His initial view of her character was that '[s]he appears at first to be thoughtful, pleasant and essentially a decent person'¹⁹¹ but he would later state that she was manipulative, deceptive and would lie to achieve her ends.¹⁹² He did not trust the psychiatric assessments of the mother believing instead that she had gone to great lengths to deceive doctors about her mental health.¹⁹³ He formed the view that her treating psychiatrist, whom she saw monthly and who had not prescribed her any medication because he believed her to be healthy, had been duped.¹⁹⁴ The judge's opinion was that the mother's condition, history and expressed delusions meant that she posed a physical and psychological risk to the child's welfare.

Justice Cohen was also extremely critical of DOCS which 'knew that the mother was schizophrenic' and psychotic.¹⁹⁵ DOCS' past supervision of the mother had generated reports that she was caring well for the child and that the child was happy.¹⁹⁶ When the mother's untreated schizophrenic delusions resulted in the mother fingerprinting the child twice a day, the child was removed and placed into the care and protection of the Director General of DOCS pursuant to s. 43(1) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW). However, Cohen J formed the belief that DOCS had abandoned, or failed in its essential duty to the child, and he expressed his concerns about the Department's ability to protect children who need protection.¹⁹⁷ Trying to rationalise DOC's support of the 'mentally ill' mother, and understand why it had refused to inform the father of the

¹⁹⁰ Ibid, 11.

¹⁹¹ Ibid.

¹⁹² Ibid 63.

¹⁹³ Ibid 99.

¹⁹⁴ Ibid 70.

¹⁹⁵ Ibid 45.

¹⁹⁶ Ibid 47.

¹⁹⁷ Ibid 44.

child's whereabouts,¹⁹⁸ he surmised that it was because the mother had complained to DOCS, as she had to the court, that the father was violent to her. However, he believed that even '[i]f her complaints were true, the child would still have been safer with the father than with the mother.'¹⁹⁹ It seemed that in the judge's mind, a child is better placed with a violent father than with a mother with a mental illness.

During an incident of irrational behaviour, the mother had thrown three objects at the father, and pushed him while he held the child. The trial judge believed that this occasion demonstrated the mother's greater propensity for violence.²⁰⁰ 'Even if the father had been as violent as the nebulous claims of the mother suggest, this would be far from a sufficient reason to depart from the orders which would be made if there had been no violence'.²⁰¹ The judge was satisfied, however, that despite the mother's complaints of a history of violence, the only time the father had assaulted her was in the circumstances in which his actions, 'if not wholly excusable, are quite understandable and do not indicate that he is a person of violent disposition'.²⁰² Cohen J believed that 'the most worrying risk that the mother posed to the child was known and unknown delusional beliefs and any which she might develop'.²⁰³ He accepted that the risk of the mother's violence was quite remote but stated '[n]o matter that this is a very remote possibility, the Court cannot discount the risk to the extent that it is regarded as acceptable'.²⁰⁴ Cohen J went on to make an order that there was to be no contact, supervised or otherwise, including telephone contact, between the mother and the child.

As a consequence of applying to the court for the formalisation of access arrangements, and contrary to the wishes of the child's father, the law stripped the mother with a mental illness of all contact with her child. This case can be contrasted with the case of *Connor & Hulett*²⁰⁵ in which the court made an order giving regular supervised and telephone contact to a father with a serious psychotic illness who had a history of compelled treatment and aggressive and violent behaviours.

¹⁹⁸ Ibid 43.

¹⁹⁹ Ibid 45.

²⁰⁰ Ibid 41.

²⁰¹ Ibid 127(j)

²⁰² Ibid 41.

²⁰³ Ibid 127(k).

²⁰⁴ Ibid.

²⁰⁵ *Connor & Hulett* [2011] FamCA 196.

5.6.1.1 'Bad mothers'

Mothers have long been venerated by the courts which have considered that she alone had the patience and sympathy necessary to mould and soothe a child's mind in its adjustment to its environment'.²⁰⁶ In 1945, High Court Chief Justice Latham stated that 'the mother is entitled to custody except where there is the strongest evidence that her custody would be detrimental to the child'.²⁰⁷ The Court reaffirmed this view point in 1961 when it concluded that there was a strong presumption, although not one in law but founded on experience, that a young child should be raised by the mother.²⁰⁸ However, as Justice Glass made clear in *Epperson v Dampney*, this poeticised bond only exists between a child and the 'good mother'.²⁰⁹

There is a general presumption that a mother who has a mental illness is by diagnostic consequence, an unfit parent. The perception of her as a helpless, naïve, inexperienced, irresponsible, unpredictable, scatty, tearful, disorganised and dangerous 'mad' mother continues to fuel society's belief that she is incapable of fulfilling the responsibilities of caring for a child. Courts will frequently focus on the mother's mental illness as the basis for removing a child and terminating her parental responsibilities.²¹⁰ Rather than grounding their findings in demonstrated harm to the child, judges frequently base them on stereotypical assumptions of bad mothering.²¹¹

In making their decisions, judges often rely on the myths of good mothers and bad mothers and in so doing, perpetuate and re-create the myths of motherhood....In cases terminating parental rights, however, the judges do not feel compelled to define the nexus between the behavior or status of the mother and harm to the child. Because they assume that their readers have internalized the same mythology, they often give information that appeals to the reader on a non-rational level: once you know this one piece of

²⁰⁶ *Jenkins v Jenkins*, 181 N.W. 826, 827 (Wis. 1921)

²⁰⁷ Latham C.J., *Storie v Storie* (1945) 80 CLR

²⁰⁸ *Kades v Kades* (1961) 35 ALJR 251

²⁰⁹ *Epperson v Dampney* (1976) 1 Family Law Note No 29, 10 ALR 227

²¹⁰ Paul Bernstein, 'Termination of Parental Rights on the Basis of Mental Disability: A Problem in Policy and Interpretation' (1991) 22 *Pacific Law Journal* 1155.

²¹¹ Jane C. Murphy, 'Legal Images Of Motherhood: Conflicting Definitions From Welfare "Reform," Family, And Criminal Law', (1998) 83 *Cornell Law Review* 688.

information about this mother (or these pieces of information), it is clear what the result in this case should be.²¹²

The court ordered outcome in *Michael and Lodders* appears exceptionally harsh and unfair for the mother. It is extremely difficult to accept that based on her mental illness, she was not labelled, stereotyped, blamed and punished by a sanist court.

6. RECENT FAMILY LAW PARENTING DECISIONS IN WHICH PARENTAL MENTAL ILLNESS WAS AN EXPLICIT OR IMPLICIT FACTOR

A review of 322 Australian family law parenting orders made between 2006 and 2011 was conducted as an original contribution to this thesis. Judgements of the Family Court of Australia and the Federal Magistrates Family Law Court that had been uploaded to the Australasian Legal Information Institute (Austlii) were searched using the broad key input term, ‘mental illness’. The search returned 322 cases. On examination, less than 10% of the 322 cases dealt with other family matters such as property, divorce, relocation, name change and procedural issues.

Once these cases were removed, 296 parenting matters remained. They all featured, with varying levels of prominence in the decision-making process, assessments of ‘meaningful relationship’, ‘best interest of the child’, and predictions of ‘risk’. Most commonly, risk was connected to future emotional or psychological harm rather than to physical harm. A reading of the judgments tended to support the proposition that parents with a history of mental illness are often viewed by courts as an ‘unacceptable risk’. Even when courts found that the parent did not represent a risk, behaviours that the party had exhibited many years earlier were seen to influence the current decision-making. For example, in the 2009 case of *Fosbery & Fosbery*, the reasons for judgment included the assessment that ‘[t]he mother’s mental unwellness post 2003 did make her detached’.²¹³ The courts rarely appeared to consider that it might be in the child’s best interests to grant the parent with a

²¹² Odeana R Neal, ‘Myths and Moms: Images of Women and Termination of Parental Rights’ (1996) 5 *Kansas Journal of Law & Public Policy* 61, 67.

²¹³ *Fosbery & Fosbery* [2009] FamCAFC 51 (30 March 2009) at 29 (49).

mental illness the outcomes that they sought if those outcomes were contrary to the submissions of the party who did not have an experience of mental illness.

The sample was manipulated by removing those judgments in which a ‘mental illness’ label was attached to both parties as were the cases in which convincing medical evidence was submitted to show that the parent had a mental illness but because of their ‘lack of insight’ into their illness, they denied having a mental illness such as was the case in *ZSP & AH*.²¹⁴ Additionally, cases in which there was medical evidence to indicate that the parent was acutely unwell at the time of the proceedings were discarded. This left cases that were circumstantially less complicated. The cases focused on a single parent with a diagnosis of a mental illness, and on cases in which certain factors were present that suggested to the courts that they could have a mental illness.

The four cases presented below were selected because they are examples of how judges, when undertaking the difficult task of weighing and balancing the interests and protection of children in parenting matters, seem to amplify the ‘fear and loathing’ associated with mental illness. As argued throughout this thesis, these attributes are apparent in the legislation that judges must interpret, and are characteristics of the values and beliefs that they consciously or unconsciously follow when applying the law (See Chapter Five, Sections 6.1 and 6.2).

This study lays open a rich avenue for future research to better determine the extent that family law judges, consciously or unconsciously, interpret parenting legislation and make parenting decisions that are rooted in the stereotypical belief that the ‘mentally ill’ parent is an ‘unfit parent’. The review of the 296 cases in this study suggests that to varying degrees, parents that are labelled with the tag of mental illness are treated more harshly and less fairly than the parent not so labelled. The cases presented below were chosen because they best represent the different types of situations in which a court appears to have treated a parent thought to have a mental illness extraordinarily harshly and unfairly.

²¹⁴ *ZSP & AH* [2007] FMCAfam 607.

6.1 Case study - *KN v Child Representatives and Others*²¹⁵

In the case of *KN v Child Representatives and Others*, proceedings for a residence order were commenced by the grandparents of a child who had been living with the grandparents since their daughter had been admitted to a psychiatric hospital. They alleged that the child had complained to them that the mother's de facto partner had acted in a sexually inappropriate manner; that he and the mother had a violent relationship; and they asserted that the child was at risk due to the mother's psychiatric condition.

Regarding the mother's mental health, the expert psychiatric witness gave evidence that at the time the mother showed no evidence of her past severe mental illness; did not appear to be in immediate need of psychiatric care;²¹⁶ and that it was unlikely the past illness would reoccur.²¹⁷ He advised the court that the return of the child into her mother's care would, in fact, be very positive in terms of the mother's mental health.²¹⁸ The child representative supported this proposed outcome. The trial judge decided, however, that although it was 'with extreme reluctance in the face of the recommendations of the child representative'²¹⁹ it was an unacceptable risk for the child to live with her mother.²²⁰

The mother and the child representative challenged the decision on appeal to the Full Court which found that the decision was unsafe and the judgment could not stand.²²¹ The court's assessment of the evidence of violence did not support the trial judge's finding that there was a serious risk to the child's welfare²²² although the court did not know what weight the trial judge had afforded violence in his combination decision.²²³ Regarding the issue of sexual abuse the trial judge had stated that 'if I were only to have to take into consideration matters relating to sexual abuse I could not find that there would be an unacceptable risk to [K] in her living with her mother'.²²⁴

²¹⁵ *KN v Child Representatives and Others* [2006] FamCA 611.

²¹⁶ *Ibid.*, 17.

²¹⁷ *Ibid.*, 86.

²¹⁸ *Ibid.*

²¹⁹ *Ibid.*, 34.

²²⁰ *Ibid.*

²²¹ *Ibid.*, 102.

²²² *Ibid.*, 98.

²²³ *Ibid.*, 99.

²²⁴ *Ibid.*, 23.

The Appeal Court found that the trial judge had placed significant emphasis on the mother's mental health and the risk that she might attempt suicide at some time in the future.²²⁵ The judge had expressed his deep concern about this possibility which, although he considered that in itself it was unlikely to satisfy 'unacceptable risk', when contemplated in combination with other matters, it had influenced his decision.²²⁶ In the later case of *Johnson v Page*,²²⁷ the Full Court would go on to decide that the components that form a conclusion of 'unacceptable risk' do not each have to be satisfied on the balance of probabilities but that 'unacceptable risk' can be established by an accumulation of factors which none, or only some of the factors reach the standard of proof.²²⁸

A difficulty for the court was trying to understanding why the trial judge had disregarded the evidence of the expert witness with regard to risk to the child being unlikely as well as accepting options available to the court that presented greater risks.²²⁹ Another difficulty was in understanding the judge's criticism of the mother's response to the allegation that her partner had sexually abused her child.

Although she is not the abuser, the mother, not the perpetrating father, is frequently held responsible for child abuse either because of her presumed failure to protect her child or because of her silence.²³⁰

The judge claimed that she denied that the abuse had occurred and he saw this attitude of denial as an example of her poor parenting.

in the circumstances given the gravity of the allegations and their consequences I would have expected a different response and it indicates in part the attitude of the mother to parenting. This attitude is not so severely inadequate as in itself to prevent [K]'s living with her mother but it is one further event in the over-all suite of concerns expressed by Ms Tonkin which I find to some extent compelling.²³¹

The Appeal Court found that the judge's statement did not reflect the evidence. The court determined that when the allegations were first brought to her attention by the

²²⁵ Ibid, 100.

²²⁶ Ibid, 133.

²²⁷ *Johnson and Page* [2007] FamCA 1235; (2007) FLC [93-344].

²²⁸ Ibid, (May, Boland and Stevenson JJ), 68.

²²⁹ Ibid, 101

²³⁰ Bernardine Dohrn, 'Bad Mothers, Good Mothers, and the State: Children on the Margins' (1995) *University of Chicago Law School Roundtable* 1, 7.

²³¹ Ibid, 26.

Department of Community Services, she had ‘said rather poignantly: “I wanted it cleared up for myself, that there was no room for error, that there could have possibly anything been done to [K]”’.²³² The court was also critical of the trial judge’s failure to explain what ‘different response’ he had expected, and how her failure to give that different response indicated an inappropriate attitude in regard to her parenting obligations particularly, as it was so compelling as to be a relevant consideration of the outcome of the case.²³³

The assumption that the woman is a "bad mother," or at least an inadequate mother in a "dysfunctional family," may lead the state to remove her children in order to protect them even when there is no child abuse.

The mother in this case clearly confronted a sanist court driven by myths and stereotypes. She was labelled an ‘unfit parent’ because of the combination of allegations that she was a victim of domestic violence, that her child was sexually abused by her partner, and that she had a past history of mental health problems including suicide attempts. Yet, to arrive at his decision, the trial judge had to disregard and distort evidence, and accept assertions that were not supported by evidence at all. He manipulated the case to satisfy his personal value and belief that children are best placed in the care of responsible, kindly and loving grandparents than in the care of a ‘mentally ill’ parent.

6.2 Case study - Langmeil and Grange²³⁴

In an adversarial family system, it is almost mandatory to discredit the other party.²³⁵ Allegations of child abuse and neglect are commonly raised in parenting disputes although doing so exposes the parent to judicial analysis as to whether making the claim is an indicator that they are ‘mentally ill’. New Zealand’s High Court Justice Thomas stated in *Gooch v Gooch*, that when a mother raises such a claim in the family court, ‘her motives are viewed with suspicion. It is suspected that she is seeking to discredit the father and so advance her claim to custody or to restrict the father’s access. Her credibility is put squarely in issue’.²³⁶

²³² Ibid, 27

²³³ Ibid, 28

²³⁴ *Langmeil and Grange* [2010] FamCAFC 12.

²³⁵ Peter G Jaffe, Nancy K D Lemon and Samantha Poisson, *Child custody & domestic violence: a call for safety and accountability* (Sage Publications, 2003) 59.

²³⁶ *Gooch v Gooch*, High Court, Christchurch M156/82, 22 April, 1983.

Emeritus Professor and child protection expert, Freda Briggs²³⁷, believes that women who accuse their former partners of sexually abusing their children are being unfairly labelled as mentally ill in the Family Court.²³⁸ Allegations are commonly explained as products of maternal coaching driven by ‘delusion’, ‘enmeshment’ or ‘vengeance’, and mother’s who refuse to accept judicial decisions face loss of residence and contact with their children.²³⁹ Some solicitors advise their clients not to raise concerns of sexual abuse because they will seem to be obstructive,²⁴⁰ and an unfriendly parent, the worst thing possible in the family court.²⁴¹

In matters in which a sexual abuse allegation is made and the mother has an established diagnosis of a mental illness, courts do not find it too difficult to justify their decision that the mother’s mental health issues – her delusional beliefs – is an unacceptable risk if it decides that the risk of the sexual abuse by the father is not unacceptable. Even when the medical evidence indicates that the mother does not have a mental illness, the court may regard the allegation as sufficient evidence to decide that the child is at ‘unacceptable risk’ if in the care of the mother.²⁴²

The case of *Langmeil and Grange* was heard on appeal by the full court from the lower court decision of Bell J who had ordered that the children, who had been living with their mother, were to live with their father, to whom the judge gave sole responsibility for their parental care. The mother had made numerous claims against the father and his family, alleging they had sexually abused the children.²⁴³ The judge, however, found that no such abuse had occurred. He ordered the mother to undergo psychiatric counselling that was directed to the issue of ‘the mother’s near delusional beliefs concerning what she perceives to be the father’s sexual abuse of the children’.²⁴⁴

²³⁷ Professor Briggs, from the University of South Australia, specialises in research into child sex abuse

²³⁸ Alicia Wood, ‘Cries of child abuse bounce back on mums’, *Sydney Morning Herald* (online) 28 March 2010 <<http://www.smh.com.au/national/cries-of-child-abuse-bounce-back-on-mums-20100327-r49d.html>>.

²³⁹ Elspeth McInnes, Freda Briggs and Charles Pragnell, ‘Flawed Family Law: Failing Sexually Abused Children’ (Australian Institute of Family Studies, 2012) <<http://aifs.gov.au/conferences/aifs12/mcinnessslides.pdf>>.

²⁴⁰ Wood, above n 238.

²⁴¹ Ibid.

²⁴² Amy Neustein and Michael Leshner, *From Madness to Mutiny -- Why Mothers are Running from Family Court and What Can Be Done About It* (Northeastern University Press, 2005).

²⁴³ This issue was brought back before Justice Stevenson in a Magellan proceeding in *Langmeil v Grange* (No. 4) [2011] FamCA 605 and again in *Langmeil v Grange* (NO. 2) [2012] FamCA 588.

²⁴⁴ *Langmeil v Grange* [2008] FamCA 1260, 62(5).

The appeal court accepted the psychiatric evidence which had also been presented to Bell J, which was that the mother did not have a mental illness and that she was not delusional. However, in pointing to statements made by Bell J where he had referred to ‘conduct on the part of the mother that he regarded as being ‘delusional behaviour’,²⁴⁵ ‘the mother’s “delusional actions”’,²⁴⁶ and ‘the mother’s “delusional beliefs”’,²⁴⁷ the court explained that ‘his Honour did not find that the mother was mentally ill, nor did he find she was delusional in the psychiatric sense.’²⁴⁸ Surprisingly, although the court noted that the judge had ordered the mother to undergo psychiatric counselling, it distinguished the order by suggesting that it was psychiatric counselling for her ‘near delusional beliefs’²⁴⁹ rather than for any actual, psychiatric condition.

Justice Bell did not, in contra regard to the psychiatric evidence which stated that the mother did not have a mental illness, expressly state that the mother did have a mental illness although his published perceptions of her presentation, behaviour and character suggest that that was what he believed. Although not mentioned by the Appeal Court, he had referred to the mother’s ‘continued unjustified, bizarre and delusional actions in relation to the allegations against the father’.²⁵⁰ Bell J also stated that the mother in evidence presented somewhat bizarrely, and had a most unfortunate manner in the court. She had tended to laugh inappropriately and was not a person that gave him very much confidence in her ability to look at reality.²⁵¹

It seems that in the judge’s mind, the mother’s ‘delusions’ were clearly distinct from her bizarreness, and that overall, the totality of her unacceptable behaviours indicated, at least to him, that she was ‘mentally ill’. Given that the medical evidence stated that she did not have a mental illness and was not delusional, it suggests that the court may have been prejudiced according to the standard definition of prejudice which is ‘any unreasonable attitude that is unusually resistant to rational influence’.²⁵² This sidestepping or disregard of psychiatric evidence

²⁴⁵ *Langmeil & Grange* [2010] FamCAFC 12, 6.

²⁴⁶ *Ibid* 39.

²⁴⁷ *Ibid* 50.

²⁴⁸ *Ibid* 290.

²⁴⁹ *Ibid*, 291.

²⁵⁰ *Ibid*, 39.

²⁵¹ *Langmeil & Grange* [2008] FamCA 1260, 14.

²⁵² Ralph L Rosnow, ‘Poultry and Prejudice’ (1972) 5 *Psychologist Today* 53.

favourable to the party but contrary to the outcomes reached by the decision-maker was apparent in a number of the cases.

6.3 Case study - Velkov & Tudor-Brown²⁵³

The case of *Velkov & Tudor-Brown* examined the risk of psychological abuse to a child. The mother had appealed against interim orders that had radically changed the parents' previous, long standing, equally shared care arrangements.²⁵⁴ The interim orders made by Altobelli FM required that the child was to no longer live with the mother and instead, live with the father. The mother was only permitted to spend three hours of supervised time with the child twice a week. The catalyst for the court proceedings was the mother's claim that the child had disclosed sexual abuse by the father. In response, the father asserted that the child was subject to the risk of 'unacceptable psychological abuse' if she remained in the care of the mother. It appears that in this case, there was no evidence submitted to the courts that either party had experience of a mental illness.

Appealing the interim orders, the mother and the children's representative argued that the Federal Magistrate had erred in finding that there was an 'unacceptable risk of psychological abuse' if the child was in the care of the mother. While he had thought that there was a risk to the child in the theoretical sense in both households, he had considered the risks were different in magnitude.

I do not regard the risk of exposing the child to sexual abuse in the father's household to be an unacceptable one ... The magnitude of the risk to the child in the father's household is not significant. Nonetheless, I believe that I can further reduce the risk by imposing certain restrictions on the father's activities involving the child that might otherwise give rise to the possibility of abuse Conversely, I am concerned about the magnitude of risk in the mother's household. The risk of psychological abuse to this child is unacceptable. I have concerns that the manner in which these allegations have been raised exposes the child to harm. I am concerned about what the mother says to the child when she is with her. For the time being I am confident that the child can be protected in the father's household. I do not have the same confidence in the

²⁵³ *Velkov & Tudor-Brown* [2007] FamCA 547.

²⁵⁴ *Ibid*, 41.

mother's household. My task and responsibility is to protect the child and I am satisfied in this case that this is the best way to achieve this.²⁵⁵

On appeal, the Full Court found that the judge had not given reasons for his finding that there was an unacceptable risk of psychological abuse if the child should live in the mother's household.²⁵⁶ He had not conducted an analysis of the risk of psychological abuse, nor had he considered what safeguards could be put in place to overcome the risk in a similar way to the exercise he had undertaken in respect of the alleged risk in the father's household.²⁵⁷ The court ordered that the relevant orders made by Altobelli FM be set aside.

When fathers who are alleged to have perpetrated sexual abuse upon their children come before the courts, the courts are generally willing to set in place safeguards to overcome the risk to the child. Courts are prepared to do this even in cases where the parent has a history of violence,²⁵⁸ is a registered sex offender,²⁵⁹ or has actually been convicted of sexually abusing their child.²⁶⁰ The view of the court has traditionally been that '[t]he consequences of denying contact between the abusive parent, usually the father, and the child may well be as serious as the risk of harm from abuse'.²⁶¹

This compassion and latitude does not, however, appear to extend to the parent who presently has, or in the past has had, a mental health diagnosis. Nor does it extend to the parent that the court, contrary to medical evidence, has a conscious, or unconscious, irrational belief that they are 'mentally ill'. Sanism is built on irrationality, stereotypes and myths. In cases of accusations by mothers of their former partners sexually abusing their children, even though the mental health of the parent is not a factor in the proceedings, the nature of the proceedings can result in the label of 'mental illness' being applied subconsciously by judges. In this way, judges can justify classifying the accuser as incapable of safe parenting and their potential for harm as permanent and irreparable. Unlike sexual abuse, with mental illness there is no need to manage the risk if you remove the child.

²⁵⁵ Ibid, 34 -35.

²⁵⁶ Ibid, 55.

²⁵⁷ Ibid, 57.

²⁵⁸ *Morcombe & Preston* [2010] FamCA 165.

²⁵⁹ *Robins & Ruddock* [2010] FamCA 35.

²⁶⁰ *D'Agostino* (1976) 30 FLR 509.

²⁶¹ *Murphy & Murphy* [2007] FamCA 795, [84].

6.4 Case study - Donaghey & Donaghey²⁶²

Justice Murphy's decision in *Donaghey & Donaghey* succeeded in raising the ire of parents and children's organisation across Australia. The National Peak Body for Safety and Protection of Parents and Children headlined on its website, 'Raise sexual abuse and lose your child for good!'²⁶³ Justice Murphy had ordered that a six year old be removed from his mother's care and live with his father, who was someone who had no experience in the role of being a single, full-time, primary carer. The judge ordered that the mother's contact with the child was to be delayed, and then limited and supervised in the future. In arriving at his decision, the judge dismissed the evidence of witnesses including a psychiatrist and a psychologist, whose opinions were that the child was a victim of sexual abuse.

The parents separated when the child was 16 months old. For the following five years, the father had short access periods that at the mother's insistence were supervised by her. In 2009, the mother sought orders to continue this arrangement. The father successfully sought orders that the child live with his mother but that he have increasing periods of access to the point that the child would spend alternate weekends and half school holidays with him. The mother alleged that the father sexually abused to child during access visits and the child reported that his father has threatened to kill him.²⁶⁴

At this hearing, Justice Murphy pathologically decided that although the mother did not have a mental illness diagnosis, she had fixed ideas that, while less than delusional were not entirely realistic or rational. He negatively assessed her presentation in the witness box, finding her 'to be a highly anxious person', 'upset' and under 'very severe, stress'.²⁶⁵ Interestingly, the language used by Justice Murphy mirrors the statement made by Merrilyn McDonald in her article, *The Myth of Epidemic False Allegations of Sexual Abuse in Divorce Cases*: 'The mother may present to the court as anxious, stressed and upset about the situation, which in

²⁶² *Donaghey & Donaghey* [2011] FamCA 13.

²⁶³ National Peak Body for Safety and Protection of Parents and Children, *Raise sexual abuse and lose your child for good!* (2013) Safety 4 parents and kids
<http://www.safety4parentsandkids.org.au/index.php?option=com_content&view=article&id=284:raise-sexual-abuse-and-lose-your-child-for-good&catid=68:family-law-cases-of-interesthttp://www.safety4parentsandkids.org.au/index.php?option=com_content&view=article&id=284%3Araise-sexual-abuse-and-lose-your-child-for-good&catid=68%3Afamily-law-cases-of-interest&Itemid=65>.

²⁶⁴ *Donaghey v Donaghey* [2011] FamCA 13, 1-2.

²⁶⁵ *Donaghey v Donaghey* [2011] FamCA 13, 96, 174, 177.

some minds seems to support the idea of her insanity'.²⁶⁶ And while the judge thought that the mother's belief that her former husband had sexually abused the child was a genuine belief,²⁶⁷ and a belief that was also held by the child,²⁶⁸ he found that the father did not represent an 'unacceptable risk' to the child as the mother had alleged.

In arriving at his decision, he had given more weight to the impression that he had formed of the father's 'good and very healthy relationship'²⁶⁹ with a previous wife and the child of that relationship. In contrast, the intensity of the mother's views²⁷⁰ persuaded him that the father did 'not pose any risk of harm to the child',²⁷¹ and that if the child continued to live with his mother, he would suffer very serious psychological harm²⁷² from which he needed the court's protection.²⁷³ The idea that a woman may be angry, malicious and mentally ill, but her allegations of sexual abuse still may be genuine is not a common consideration of the courts.²⁷⁴

The cases reviewed suggest that family courts are not always willing to set in place the community supports necessary to reduce risks to enable parents experiencing a mental illness continued contact with their child. There are opportunities within the community for assessment, support and intervention. There are services that take a holistic approach to the needs of families around clinical and social supports for parents and children. Education of children about mental illness is available. There is also provision for intensive family therapy²⁷⁵ albeit insufficient. However, the courts' continued use of the measure of 'unacceptable risk' rather than 'significant risk' in parenting matters makes it appear that it is more likely that parents who experience mental illness will have their parental responsibilities severely restricted or lose them altogether.

²⁶⁶ Ibid 18.

²⁶⁷ Ibid 230.

²⁶⁸ Ibid 222.

²⁶⁹ Ibid 238.

²⁷⁰ Ibid 96.

²⁷¹ Ibid 234.

²⁷² Ibid 235.

²⁷³ Ibid.

²⁷⁴ Marilyn McDonald, 'The Myth of Epidemic False Allegations of Sexual Abuse in Divorce Cases' (1998) Court Review 12, 18.

²⁷⁵ Ibid.

7. CONCLUSION

Parenting has been identified as the most significant variable implicated in the development of a child and consequently designated as society's most important public health issue.²⁷⁶ This import has generated an abundance of primarily, pathologically focused research on the parenting capabilities of members of marginal and disadvantaged groups such as the intellectually disabled, substance users and people who have a mental illness. Research has predominately taken the disease approach which carries the implicit presumption that people who have a mental illness are abnormal although the findings are at times appear contradictory.²⁷⁷ Some researchers suggest that research on the effects of mental illness on parenting is limited.²⁷⁸ The majority, however, conclude that parental mental illness results in problematic parenting practices that negatively influence a child's development.²⁷⁹

The purpose of Chapter Six was not to discount or trivialise the real risks that some children in situations of parental mental illness can confront. Its purpose was to highlight the fact that the stigmatising, stereotyping and labelling of all parents who experience mental illness often results in the unfair loss or restriction of their parental responsibilities. Inherently biased courts fail to draw what should be the necessary nexus between the parent's illness and reliable evidence regarding their present and future parenting capacity. This is largely because established within the legal system is the sanist presumption that mental illness is synonymous with poor parenting. This presumption is implicitly and explicitly endorsed by health and human policies and child protection and family law statutes. It provides the foundation on which legal decision-makers construct their decisions.

²⁷⁶ Masud Houghghi, 'The importance of parenting in child health' (1998) 316 *British Medical Journal* 1545.

²⁷⁷ Maybery, Darryl., Andrea Reupert, Kent Patrick, Melinda Goodyear, Lin Crase, 'Vic Health Research Report on Children at risk in families affected by parental mental illness' (2005) Victorian Health Promotion Foundation Mental Health and Wellbeing Unit, <http://www.fcms.net.au/documents/documents/Children%20at%20Risk%20in%20Families%20Affected%20by%20Mental%20Illness%20.pdf>

²⁷⁸ Huntsman, Leone 'Parents with mental health issues: Consequences for children and effectiveness of interventions designed to assist children and their families' (Literature review, Centre for Parenting & Research Service System Development Division New South Wales Department of Community Services, 2008).

²⁷⁹ Daphna Oyserman *et al.*, 'Parenting Among Mothers With a Serious Mental Illness' (2000) 70 *American Journal of Orthopsychiatry* 296. See also Sally K Gallagher and David Mechanic, 'Living with the mentally ill: Effects on the health and functioning of other household members' (1996) 42 *Social Science & Medicine* 1691. See also Diane Garley *et al.*, 'Children of the mentally ill: a qualitative focus group approach' (1997) 4 *Journal of Psychiatric and Mental Health Nursing* 97.

Although there is a legal onus on people experiencing a mental illness to prove, in limited situations, that they are incapable,²⁸⁰ the far more onerous burden is placed on parents experiencing a mental illness to prove in family law that they are, in fact, capable.²⁸¹ The parent must not only prove that they satisfy the legal standard of mental capacity but that they also have the social capacity to function according to an amorphous set of idealised parenting norms. They are also required to do this in an environment where their parenting skills are assessed against perceived risks that are driven by the notion that all parents with mental illness are a risk to their children. The legal system reinforces the public perception that because of their mental illness, these parents are, or potentially are, abusive and/or neglectful of their children. Their narratives are viewed as less credible when measured against the contradictory evidence of more powerful actors such as police officers, welfare workers, mental health experts, legal representatives and opposing parties who do not have a mental illness diagnosis.

Having entered the family law system, the parent quickly realises that the making of a parenting order may be the most significant issue that they will ever face because they can lose the opportunity to parent their child even when it is in the child's best interest that they do so.²⁸² Carrying the label of mental illness signals to the decision-maker that the parent conveys with them an array of potential harms and unacceptable risks ranging from not helping the child with their homework or hugging them enough to committing infanticide. This blame approach propels the need to subject parents to constant predictive risk assessments. For the decision-maker, the availability of a broad focus of unspecified risks makes it easier for them to err on the side of caution.

Theoretically, the law guides and controls parenting decisions but in practice, it is the prevalence of vague rules and unclear meanings that direct decision-makers

²⁸⁰ An example is section 15 of the *Criminal Code 1924* (Tas) which presumes the defendant's sanity. Section 16(1) of the *Criminal Code 1924* (Tas) requires the defendant to prove that he was not criminally responsible for an act done or an omission made by him because he had a mental disease which rendered him incapable of understanding the physical character of such act or omission; or knowing that such act or omission was one which he ought not to do or make.

²⁸¹ Joanne Nicholson, J., Sweeney, E.M., Geller, J.L., Focus on Women: Mothers With Mental Illness: I. The Competing Demands of Parenting and Living With Mental Illness, 49 *Psychiatric Services*, pp.635-642, May 1998 "From the outset our clients have to prove they're able to parent, unlike everybody else who is able to assume they can parent until they prove otherwise." *The Family Law Act 1975* (Cth) requires that the parent has the capacity to care for the child s 60CC(3)(f)(i).

²⁸² Anat S Geva, 'Judicial Determination of Child Custody When a Parent is Mentally Ill: A Little Bit of Law, A Little Bit of Pop Psychology, and A Little Bit of Common Sense.' (2012) 16 *UC Davis Journal of Juvenile Law & Policy* 1, 8.

toward making value judgements that they believe to be in the child's future, undefined, best interests. In the public mind, mental illness is indelibly associated with dysfunction, interpersonal violence, homicide and suicide. In the mind of the legal system charged with protecting children, these associations assume that the parent's mental illness makes them unable to keep their child safe from harm from self or others. The child's interests and welfare is, and should be, paramount when predicting the risks associated with inadequate or improper parenting. The problem, however, is that sanism magnifies any risk to an unacceptable level. Sanist courts are rarely willing to move beyond blind acceptance of the stigmatised and stereotypical relationship of mental illness with unacceptable risk which leads to decision-making that can unfairly disadvantage the parent, as well as the child.

This chapter has demonstrated that, as Perlin has long argued, sanism appears to be pervasive in the legal system, or at least, in the small area of the legal system examined as part of this thesis: the area in which allegations of unfit parenting are made and decided. A discussion of the concepts of good and bad parenting showed that the stigma and stereotypes associated with mental illness significantly influence social research which, in turn, reinforced the law's expectations of what constitutes a good parent set out in child protection and family law legislation. They are also reflected in the case study decisions drawn from the review of recent Australian family law parenting orders which showed that courts determine a good parent to be a parent who is devoid of the 'unacceptable risk' of mental illness.

Chapter Six has shown that stigmatising, stereotyping, labelling and discrimination is prevalent. Chapter Seven presents an option for changing the negative attitudes and behaviours that both fuel sanism in the legal system, and are products its insidiousness. It suggests that the participation of law students in a therapeutic jurisprudence based clinical program such as Mental Health Tribunal Representation Scheme may help to positively improve the attitudes of future legal professionals. They then may help to break down the legal system's sanist barriers thereby increasing the opportunities for people who experience mental illness to receive fair and equitable legal outcomes.

BIBLIOGRAPHY

A. Articles

- Ackerson, Barry J, 'Coping with the dual demands of severe mental illness and parenting: the parent's perspective' (2003) 84 *Families in Society: The Journal of Contemporary Human Services* 109.
- Ackerson, Barry J, 'Parents with serious and persistent mental illness: Issues in assessment and services' (2003) 48 *Social Work* 187.
- Appleby, Louis and Chris Dickens, 'Mothering skills of women with mental illness' (1993) 306 *British Medical Journal* 348.
- Beardselee, William R, Eve M Versage and Tracy R G Giadstone, 'Children of Affectively Ill Parents: A Review of the Past 10 Years' (1998) 37 *Journal of the American Academy of Child & Adolescent Psychiatry* 1134.
- Berger, Lawrence M, 'Income, family characteristics, and physical violence toward children' (2005) 29 *Child Abuse & Neglect* 107.
- Bernstein, Paul, 'Termination of Parental Rights on the Basis of Mental Disability: A Problem in Policy and Interpretation' (1991) 22 *Pacific Law Journal* 1155.
- Browne, M Neil and Andrea Giampetro, 'The Contribution of Social Science Data to the Adjudication of Child Custody Disputes' (1985-1986) 15 *Capital University Law Review* 43.
- Budd, Karen S and Rachael E Springman, 'Empirical Analysis of Referral Issues And "Ultimate Issue" Recommendations For Parents In Child Protection Cases' (2011) 49 *Family Court Review* 34.
- Budd, Karen S, 'Assessing parenting capacity in a child welfare context' (2005) 27 *Children and Youth Services Review* 429.
- Chisholm, Richard, 'Making it work: the Family Law Amendment (Shared Parental Responsibility) Act 2006' (2007) 21 *Australian Journal of Family Law* 143.
- Chisholm, Richard, 'The meanings of 'meaningful' within the Family Law Act amendments of 2006: A legal perspective' (2009) 15 *Journal of Family Studies* 60.
- Coleman, Priscilla K and Katherine H. Karraker, 'Self-efficacy and parenting quality: Findings and future applications' (1998) 18 *Developmental Review* 47.
- Connolly, Marie and Mike Doolan, M, 'Child deaths and statutory services: Issues for child care and protection' (2007) 2 *Communities, Families and Children Australia* 26.
- Corrigan, Patrick W and Amy C Watson, 'Understanding the impact of stigma on people with mental illness' (2002) 1 *World Psychiatry* 16.
- Dohrn, Bernardine, 'Bad Mothers, Good Mothers, and the State: Children on the Margins' (1995) *University of Chicago Law School Roundtable* 1.
- Emery, Robert E, Randy K Otto and William T O'Donohue, 'A Critical Assessment of Child Custody Evaluations Limited Science and a Flawed System' (2005) 6 *Psychological Science in the Public Interest* 1.

- Evans, Richard, 'Seeking Justice for the Mentally Ill' (1995) 69 *Law Institute Journal* 642.
- Fogarty, John, 'Unacceptable risk - A return to basics' (2006) 20 *Australian Journal of Family Law* 249.
- Folberg, J, 'Family Courts: Assessing the Trade-Offs' (1999) 37 *Family Court Review* 448.
- Gallagher, Sally K and David Mechanic, 'Living with the mentally ill: Effects on the health and functioning of other household members' (1996) 42 *Social Science & Medicine* 1691.
- Garley, Diane, *et al.*, 'Children of the mentally ill: a qualitative focus group approach' (1997) 4 *Journal of Psychiatric and Mental Health Nursing* 97.
- Geva, Anat S, 'Judicial Determination of Child Custody When a Parent is Mentally Ill: A Little Bit of Law, A Little Bit of Pop Psychology, and A Little Bit of Common Sense.' (2012) 16 *UC Davis Journal of Juvenile Law & Policy* 1.
- Gillingham, Phillip 'Risk assessment in child protection: Problem rather than solution?' (2006) 59 *Australian Social Work* 86.
- Goddard, Chris R, Bernadette J Saunders, Janet Stanley and Joe Tucci, 'Structured risk assessment procedures: Instruments of abuse?' (1999) 8 *Child Abuse Review* 251.
- Hamarman, Stephanie and William Bernet, 'Evaluating and Reporting Emotional Abuse in Children: Parent-Based, Action-Based Focus Aids in Clinical Decision-Making' (2000) 39 *Journal of the American Academy of Child and Adolescent Psychiatry* 928.
- Hayman, Robert L, 'Presumptions of Justice: Law, Politics, and the Mentally Retarded Parent' (1990) 103 *Harvard Law Review* 1201.
- Hemmingsson, Tomas and Ingvar Lundberg, 'Development of alcoholism: interaction between heavy adolescent drinking and later low sense of control over work' (2001) 36 *Alcohol and Alcoholism* 207.
- Hemphill, Clara, 'Hard Choices: Caring for the children of mentally ill patients' (2009) 17 *Child Welfare Watch* 1.
- Higgins, Daryl and Ilan Katz, 'Enhancing service systems for protecting children: Promoting child wellbeing and child protection reform in Australia' (2008) 80 *Family Matters* 43.
- Hoghugh, Masud and ANP Speight, 'Good Enough Parenting For All Children—A Strategy for a Healthier Society' (1998) 78 *Archives of Disease In Childhood* 293.
- Hoghugh, Masud, 'The importance of parenting in child health' (1998) 316 *British Medical Journal* 1545.
- Joseph, Jill G, *et al.*, 'Characteristics and Perceived Needs of Mothers with Serious Mental Illness' (1999) 50 *Psychiatric Services* 1357.
- Kempe, C Henry, *et al.*, 'The battered child syndrome' (1962) 181 *Journal of the American Medical Association* 17.
- Knutson, John F, David S DeGarmo and John B Reid, 'Social Disadvantage and Neglectful Parenting as Precursors to the Development of Antisocial and Aggressive Child Behavior: Testing a Theoretical Model' (2004) 30 *Aggressive Behavior* 187.

- Kopelman, Loretta M, 'The Best-Interests Standard as Threshold, Ideal, and Standard of Reasonableness' (1997) 22 *The Journal of Medicine and Philosophy* 271.
- Kumar, R, *et al.*, 'Clinical survey of a psychiatric mother and baby unit: characteristics of 100 consecutive admissions' (1995) 33 *Journal of Affective Disorders* 11.
- Leff, Julian, 'Why is care in the community perceived as a failure?' (2001) 179 *The British Journal of Psychiatry* 381.
- Link, Bruce J and Jo C Phelan, 'Conceptualizing stigma' (2001) 27 *Annual Review of Sociology* 363.
- Llewellyn, Gwynnyth, David McConnell and Luisa Ferronato, 'Prevalence and Outcomes for Parents with Disabilities and their Children in an Australian Court Sample' (2003) 27 *Child Abuse & Neglect* 235.
- McCord, Joan, 'Family Relationships, Juvenile Delinquency, and Adult Criminality' (1991) 29 *Criminology* 397.
- McDonald, Merrilyn, 'The Myth of Epidemic False Allegations of Sexual Abuse in Divorce Cases' (1998) *Court Review* 12.
- Miller, Laura J and Molly Finnerty, 'Sexuality, pregnancy, and childrearing among women with schizophrenia-spectrum disorders' (1996) 47 *Psychiatric Services* 502.
- Mnookin, Robert H, 'Child custody adjudication: Judicial functions in the face of indeterminacy' (1975) 39 *Law and Contemporary Problems* 226.
- Moloney, Lawrie, 'Meaningful relationships' in the Family Law Act Amendments of 2006: A socio-legal perspective on fathers, mothers and the 'sharing' of parenting after separation' (2009) 15 *Journal of Family Studies* 9.
- Montgomery, Phyllis, *et al.*, 'Keeping close: mothering with serious mental illness' (2006) 54 *Journal of Advanced Nursing* 20.
- Mordoch, Elaine and Wendy A Hall, 'Children living with a parent who has a mental illness: A critical analysis of the literature and research implications, literature and research implications' (2002) 16 *Archives of Psychiatric Nursing* 208.
- Mosoff, Judith, 'Motherhood, Madness, and Law' (1995) 45 *The University of Toronto Law Journal* 107.
- Mowbray, Carol, *et al.*, 'Parenting of mothers with a serious mental illness: differential effects of diagnosis, clinical history, and other mental health variables' (2002) 26 *Social Work Research* 225.
- Mullick, Mrinal, Laura J Miller and Teresa Jacobsen, 'Insight into mental illness and child maltreatment risk among mothers with major psychiatric disorders' (2001) 52 *Psychiatric Services* 488, 489.
- Murphy, Jane C, 'Legal Images of Motherhood: Conflicting Definitions From Welfare "Reform," Family, And Criminal Law', (1998) 83 *Cornell Law Review* 688.
- Neal, Odeana R, 'Myths and Moms: Images of Women and Termination of Parental Rights' (1996) 5 *Kansas Journal of Law & Public Policy* 61

Nicholson, Joanne, Elaine M, Sweeney, Jeffrey L Geller, 'Focus on Women: Mothers with Mental Illness: I. The Competing Demands of Parenting and Living With Mental Illness' (1998) 49 *Psychiatric Services* 635.

Nicholson, Joanne, Elaine Sweeney and Jeffrey Geller, 'Mothers with mental illness: II. Family relationships and the context of parenting' (1998) 49 *Psychiatric Services* 643.

O'Hagan, Kieran P, 'Emotional and psychological abuse: Problems of definition' (1995) 19 *Child Abuse & Neglect* 449.

Oyserman, Daphna, *et al.*, 'Parenting Among Mothers With A Serious Mental Illness' (2000) 70 *American Journal of Orthopsychiatry* 296.

Payne, Anne T, 'The Law and the Problem Parent: Custody and Parental Rights of Homosexual, Mentally Retarded, Mentally Ill an Incarcerated Parents' (1977-1978) 16 *Journal of Family Law* 797.

Reupert, Andrea and Darryl Maybery, 'Families affected by parental mental illness; A multiperspective account of issues and interventions' (2007) 77 *American Journal of Orthopsychiatry* 362.

Rodgers, Bryan, 'Mental Health and the Family Law System' (2004) 10 *Journal of Family Studies* 50.

Rosen, Alan, Liz Newton and Karen Barfoot, 'Clinical Perspectives: Evidence based Community Alternatives to Institutional Psychiatric Care' (2003) 4 *Medicine Today* 90.

Rosnow, Ralph L, 'Poultry and Prejudice' (1972) 5 *Psychologist Today* 53.

Rüsch, Nicolas, Matthias C Angermeyer and Patrick W Corrigan, 'Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma' (2005) 20 *European Psychiatry* 529.

Rutter, Michael and David Quinton, 'Parental psychiatric disorder; effects on children' (1984) 14 *Psychological Medicine* 853.

Sandler, Irwin, 'Quality and ecology of adversity as common mechanisms of risk and resilience' (2001) 1 *American Journal of Community Psychology* 19.

Sheehan, Rosemary and Greg Levine, 'Parents with mental illness: Decision-making in Australian Children's Court cases involving parents with mental health problems' (2005) 27 *Journal of Social Welfare and Family Law* 17.

Sheppard, Michael, 'Double jeopardy: the link between child abuse and maternal depression in child and family social work' (1997) 2 *Child & Family Social Work* 91.

Simons, Ronald L, *et al.*, 'Parenting Factors, Social Skills, and Value Commitments as Precursors to School Failure, Involvement with Deviant Peers, and Delinquent Behavior' (1991) 20 *Journal of Youth and Adolescence* 645.

Smith, Gregory T, 'Psychological Expectancy as Mediator of Vulnerability to Alcoholism' (1994) 708 *Annals of the New York Academy of Sciences* 165.

Trinder, Liz, 'What might children mean by a 'meaningful relationship'?' (2009) 15 *Journal of Family Studies* 20.

Wisdom, Jennifer P, *et al.*, 'Stealing me from myself': identity and recovery in personal accounts of mental illness' (2008) 42 *Australian & New Zealand Journal of Psychiatry* 489.

Zuravin, Susan, *et al.*, 'The Intergenerational Cycle Of Child Maltreatment Continuity Versus Discontinuity' (1996) 11 *Journal Of Interpersonal Violence* 315.

B. Books

Ackerman, Marc J, *Clinician's Guide to Child Custody Evaluations* (John Wiley & Sons, 3rd ed, 2006).

Cicchetti, Dante and Donald J Cohen (eds), *Developmental Psychopathology* (John Wiley New York, 2nd ed, 2006).

Damon, William and Richard M Lerner (eds), *Handbook of Child Psychology: Social, emotional, and personality development* (John Wiley & Sons, 2006) Daphne Blunt Bugental and Joan E Grusec, 'Socialization Process'.

Factor, David C and David A Wolfe, 'Chapter 7 Parental Psychopathology and High-Risk Children' in Robert Ammerman and Michel Hersen (eds), *Children at Risk; An Evaluation of Factors Contributing to Child Abuse and Neglect* (New York: Plenum Press, 1990).

Galatzer-Levy, Robert M, Louis Kraus and Jeanne Galatzer-Levy, *The Scientific Basis of Child Custody Decisions* (John Wiley & Sons, 2009).

Gilman, Sander L, *Difference and pathology: stereotypes of sexuality, race, and madness* (Ithaca: Cornell University Press, 1985).

Hubbard, Douglas W, *The Failure of Risk Management: Why It's Broken and How to Fix It* (John Wiley & Sons, 2009).

Oberland, Lois Condie, *Parenting evaluations for the court: Care and protection matters* (Kluwer Academic/Plenum, 2003).

Parton, Nigel (ed), *Child Protection and Family Support: Tensions, Contradictions and Possibilities* (Routledge, 1997).

Perlin, Michael L, *The Hidden Prejudice: Mental Disability on Trial* (American Psychological Association, 2000).

Reder, Peter, Sylvia Duncan and Clare Lucey (eds), *Studies in the assessment of parenting* (Hove, Brunner-Routledge, 2003).

Reich, Warren T, (editor in chief) *Encyclopedia of Bioethics*, (Simon & Schuster MacMillan, revised ed., 1995). Lucy S McGough, 'Children/V. Child custody'.

Stephen Parker, Patrick Parkinson and Juliet M Behrens, *Australian Family Law in Context: Commentary and Materials* (LBC Information Services, 1999).

C. Grey Literature -Research Papers, Reports, Submissions, Letters, Memos etc.

Australian Association of Social Workers (Qld) Submission to the Queensland Child Protection Commission of Inquiry, August 2012,

<http://www.childprotectioninquiry.qld.gov.au/__data/assets/pdf_file/0007/161548/Healy_Karen.pdf>.

Beehag, Julia and Mitchell Little, 'Family Consultant Mental Health Support Training – Case law on Unacceptable Risk and Mental Health' (Research Memo, 12 February, 2008) <https://docs.google.com/viewer?a=v&q=cache:9sZr_kTKjmQJ:www.fcms.net.au/documents/documents/Mental%2520Health%2520and%2520Unacceptable%2520Risk%2520Case%2520Law%2520Julia.doc+&hl=en&gl=au&pid=bl&srcid=ADGEEShtZ_4XYhbnpyBFd8eH0jfi5_OT0cMSHtOazYuALCStpnuTADsfW46cRgwPY5L4fXmacUd-QI4-sdHp8-2y0fQYQb1jQ4Z9LF9quaKSq6bdSLPClqIpKOWHZFxe6Qt5zJwsqInG&sig=AHIEtbRLHxX4TPgWZ9WDWnNVocvDGVbXbA>.

Bromfield, Leah, *et al.*, 'Issues for the safety and wellbeing of children in families with multiple and complex problems: The co-occurrence of domestic violence, parental substance misuse, and mental health problems' (Research Paper No 33, Australian Institute of Family Studies, National Child Protection Clearinghouse, December 2010).

Castan Centre for Human Rights Law, Submission to the Family Law Council, *The Inquiry Into Relocation Of Children In Family Law*, April 2006.

Chisholm, Richard, 'Shared care and children's best interests: Working with the amendments of 2006' (Paper, Legal Aid NSW Family Law Conference, Sydney, 22 August, 2008).

Chisholm, Richard, 'Unacceptable risk – a comparison of the family law and care jurisdictions' (Article derived from a paper prepared for the Children's Court Conference, Parramatta, 1 September 2010).

Department for Children Schools and Families, 'Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children' (Report, Department for Children Schools and Families, March 2010), <<http://www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/workingtogether/workingtogethertosafeguardchildren/>>.

Faller, Kathleen Coulborn and Chyrell D Bellamy, 'Mental health problems and child maltreatment' (1999) <<http://141.211.91.162/public/currentProjects/icwtp/mentalhealth/d-mhpar.pdf>>.

Gardner, Ruth 'Developing an effective response to neglect and emotional harm to children', University of East Anglia and The National Society for the Prevention of Cruelty to Children, January 2008, <http://www.nspcc.org.uk/inform/research/nspccresearch/completedresearch/DevelopingAnEffectiveResponseToNeglectPDF_wdf56700.pdf>

Goldman, Jill, *et al.*, 'A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice' (Report, U.S. Department of Health and Human Services, Administration for Children and Families Administration on Children, Youth and Families Children's Bureau, Office of Child Abuse and Neglect, 2003) <<https://www.childwelfare.gov/pubs/usermanuals/foundation/foundation.pdf>>.

Grall, Timothy S, 'Custodial Mothers and Fathers and Their Child Support: 2009' (Current Population Reports No P60-240, U.S. Department of Commerce Economics and Statistics Administration United States Census Bureau, December 2011), <<http://www.census.gov/prod/2011pubs/p60-240.pdf>>.

Higgins, Daryl and Rae Kaspiew, 'Child protection and the family law...Joining the dots' (Research Paper No 34, National Child Protection Clearinghouse, 2011)
<<http://www.aifs.gov.au/nch/pubs/issues/issues34/issues34.pdf>>.

Huntsman, Leone 'Parents with mental health issues: Consequences for children and effectiveness of interventions designed to assist children and their families' (Literature review, Centre for Parenting & Research Service System Development Division New South Wales Department of Community Services, 2008),
<http://www.community.nsw.gov.au/docswr/_assets/main/documents/research_parentalmentalhealth.pdf>.

Making the Invisible Visible: Parents with Psychiatric Disabilities, National Technical Assistance Center for State Mental Health Planning, Special Issue, Parents with Psychiatric Disabilities, 2000
<<http://www.nasmhpd.org/docs/publications/archiveDocs/2000/ParentswithPsychiatricDisabilities.pdf>>

Maybery, Darryl, Andrea Reupert and Melinda Goodyear, 'Evaluation of a model of best practice for families who have a parent with a mental illness' (Research Report, Charles Sturt University, 2006).
<<https://www.easternhealth.org.au/app/cmslib/media/umlib/mental%20health/fapmi/champsreport.pdf>>

Maybery, Darryl., Andrea Reupert, Kent Patrick, Melinda Goodyear, Lin Crase, 'Vic Health Research Report on Children at risk in families affected by parental mental illness' (2005) Victorian Health Promotion Foundation Mental Health and Wellbeing Unit,
<http://www.fcms.net.au/documents/documents/Children%20at%20Risk%20in%20Families%20Affected%20by%20Mental%20Illness%20.pdf> >

McInnes, Elspeth, Freda Briggs and Charles Pragnell, 'Flawed Family Law: Failing Sexually Abused Children' (Australian Institute of Family Studies, 2012)
<<http://aifs.gov.au/conferences/aifs12/mcinnessides.pdf>>.

Merton, Rachel and Jenna Bateman, 'Social Inclusion: Its importance to Mental Health' (Research Paper, Mental Health Coordinating Council Inc., June 2007)
<<http://www.mhcc.org.au/images/uploaded/MHCC%20Social%20Inclusion%20booklet.pdf>>

National Peak Body for Safety and Protection of Parents and Children, *Raise sexual abuse and lose your child for good!* (2013) Safety 4 parents and kids
<http://www.safety4parentsandkids.org.au/index.php?option=com_content&view=article&id=284:raise-sexual-abuse-and-lose-your-child-for-good&catid=68:family-law-cases-of-interesthttp://www.safety4parentsandkids.org.au/index.php?option=com_content&view=article&id=284%3Araise-sexual-abuse-and-lose-your-child-for-good&catid=68%3Afamily-law-cases-of-interest&Itemid=65>.

National Research Council, 'Understanding Child Abuse and Neglect' (Report, National Academy Press, 1993)

Price-Robertson, Rhys and Leah Bromfield, 'Risk assessment in child protection', Australian Institute of Family Studies, March 2011
<<http://www.aifs.gov.au/nch/pubs/sheets/rs24/>>.

Ryan, Judy, 'Mental Health and Family Law - A Question of Degree' (Paper presented at 6th Annual Family Law Intensive, Sydney, 11 February 2006),

<<http://federalcircuitcourt.gov.au/pubs/docs/Speech%20-%20Ryan%20-%20mentalhealth%20-%202006.pdf>>.

Smyth, Bruce, Nicholas Richardson and Grace Soriano (eds), 'Proceedings of the International Forum on Family Relationships in Transition: Legislative, practical and policy responses' (Australian Institute of Family Studies, 1 – 2 December 2005).

Stewart, Anna, Susan Dennison and Elissa Waterson, 'Pathways from Child Maltreatment to Juvenile Offending' (Research Paper No 241, Australian Institute of Criminology, 2002).

Tomison, Adam M and Joe Tucci, 'Emotional Abuse: the hidden form of maltreatment' (Issues in Child Abuse Prevention No 8, National Child Protection Clearinghouse, 1997).

Tomison, Adam M, 'Child Maltreatment and Mental Disorder' (Discussion Paper No 3, National Child Protection Clearing House, 1996)
<<http://www.aifs.gov.au/nch/pubs/discussionpaper/discussion3.html>>.

Tunnard, Jo, 'Parental mental health problems: messages from research, policy and practice' (Research Review, Research in Practice, 2004).

United Nations, 'World Youth Report 2003: The global situation of young people' (Report, Secretary-General, 2003).
<www.un.org/esa/socdev/unyin/documents/worldyouthreport.pdf>.

Wood, J James, 'Report of the Special Commission of Inquiry into Child Protection Services in New South Wales' (Report, State of New South Wales; the Special Commission of Inquiry into Child Protection Services in New South Wales, 2008)
<<http://www.dpc.nsw.gov.au/publications/news/stories/?a=33794>>.

D. International law instruments

Convention on the Rights of the Child.

E. Legislation

Family Law Act 1975.

Care and Protection of Children Act 2007 (NT)

Child Protection Act 1999 (Qld)

Children and Community Services Act 2004 (WA)

Children and Young People Act 1999 (ACT)

Children and Young Persons (Care and Protection) Act 1998 (NSW)

Children, Young Persons and Their Families Act 1997 (Tas)

Children, Youth and Families Act 2005 (Vic).

Children's Protection Act 1993 (SA)

F. Cases

A v A (1976) VR 298.

A v A (1998) FLC 92-800.

B v B (Access) (1986) FLC 91-758.

Burke & Van Der Molen [2002] FMCA 276.

Champness & Hanson [2009] FamCAFC 96.

Connor & Hulett [2011] FamCA 196.

D'Agostino (1976) 30 FLR 509.

Donaghey & Donaghey [2011] FamCA 13.

Epperson v Dampney (1976) 1 Family Law Note No 29, 10 ALR 227

Fosbery & Fosbery [2009] FamCAFC 51

Franka and Grantham [2011] FamCA 32

Godfrey and Sanders (2007) 208 FLR 287.

Gooch v Gooch , High Court, Christchurch M156/82, 22 April, 1983.

In re G (a minor) (1987) 1 WLR 1461.

Jenkins v Jenkins, 181 N.W. 826, 827 (Wis. 1921)

Johnson and Page [2007] FamCA 1235.

Kades v Kades (1961) 35 ALJR 251

KN v Child Representatives and Others [2006] FamCA 611.

Korban & Korban, [2009] FamCAFC 143.

Langmeil & Grange [2008] FamCA 1260.

Langmeil & Grange [2010] FamCAFC 12.

Langmeil v Grange (No. 4) [2011] FamCA 605

Langmeil v Grange (NO. 2) [2012] FamCA 588.

Leveque v Leveque (1983) 54 B CLR 164.

Loddington & Derringford (No 2) [2008] FamCA 925.

M and M (1988) 166 CLR 69.

Marion's Case (1992) 175 CLR 218.

Marriage of M (1987) 11 Fam LR 765.

Mazorski & Albright (2007) 37 Fam LR 518.

McCall & Clark [2009] FamCAFC 92.

Michael and Lidders [2008] FamCA 389.

Morcombe & Preston [2010] FamCA 165.

Murphy & Murphy [2007] FamCA 795.

Ray and Males [2009] Fam CA 219

Robins & Ruddock [2010] FamCA 35.

Runcorn & Raine (2008) FamCA 837.

Secretary of the Department of Health and Human Services & Rollinson & Cheeseman & Ors [2010] FamCAFC 258.

Storie v Storie (1945) 80 CLR.

Velkov & Tudor-Brown [2007] FamCA 547.

ZSP & AH [2007] FMCAfam 607.

G. Media and websites

Australian Family Law Courts website,
<http://www.familylawcourts.gov.au/wps/wcm/connect/FLC/Home/Whats+New/FLC_family_law_changes>.

Matt Mazur, 'Mommie Dearest: An Interview with Animal Kingdom's Jacki Weaver' *PopMatters* (online), 13 August 2010 <<http://www.popmatters.com/pm/feature/129328-mommie-dearest-an-interview-with-animal-kingdoms-jacki-weaver/>>.

When a Parent Has a Mental Illness: Issues and Challenges, Mental Health America website <<http://www.mentalhealthamerica.net/index.cfm?objectid=e3412bb7-1372-4d20-c8f627a57cd3d00f>>.

Wood, Alicia, 'Cries of child abuse bounce back on mums', *Sydney Morning Herald* (online) 28 March 2010 <<http://www.smh.com.au/national/cries-of-child-abuse-bounce-back-on-mums-20100327-r49d.html>>.

CHAPTER SEVEN

THE MENTAL HEALTH TRIBUNAL REPRESENTATION SCHEME

1. INTRODUCTION

A premise of this thesis is that law students possess stereotypical and prejudicial beliefs about mental illness. It is reasonable to assume that these negative attitudes will, on entry into professional practice, help to reinforce Michael Perlin's perception of a sanist legal system that treats people with experience of mental illness unfairly and more harshly. This raises the question as to whether an intervening factor such as a student's participation in a therapeutic jurisprudence modelled clinical program similar to the Tasmanian Mental Health Tribunal Representation Scheme (MHTRS) which is evaluated in this chapter might positively alter the student's poor mental health attitudes. If this was to occur, the newly graduated practitioner may contribute to reducing stigma and decreasing discrimination in the legal system?

The earliest chapters studied the failure of public health paradigms and policies to provide the law with clear and consistent guidance and examined the law's reliance on the biomedical labelling model which stamps the person experiencing mental illness as abnormal, different, disabled, dysfunctional and dangerous. These characteristics, particularly the risk due to the potential capacity to commit harm to others were discussed in Chapter Three as factors that both drive stigma, and are produced by it. Chapter Four discussed the largely unsuccessful global strategies to reduce the stigma associated with mental illness generally, and to decrease its related discrimination. Professor Patrick McGorry, psychiatrist, mental health advocate and 2010 Australian of the Year suggested that it was society's inherent prejudice toward people with a mental illness, and its acceptance of discriminatory language that was responsible for the failure of anti-stigma policies and programs.¹

¹ Mark Metherell, 'Mental health failure tied to prejudice: McGorry', *The Age* (online), 23 June 2010 <<http://www.theage.com.au/national/mental-health-failure-tied-to-prejudice-mcgorry-20100622-yvuf.html>>.

Chapter Five moved on from the broader discussion of the themes of prejudice and discrimination to the specific examination of Michael Perlin's dual theories particular to the legal system: sanism and pretextuality. Similar to McGorry, Perlin's explanation for why it is difficult, if not almost impossible, to combat the prejudice associated with mental illness is because of its social acceptability.

Chapter Six sought to test Perlin's concept of sanism by examining it within the specific legal area of conflicted parenting. It examined the moral notion of the 'bad parent' which is inextricably linked to the abnormal, different, disabled, dysfunctional and dangerous label attached to a person who has experience of a mental illness as discussed in Chapter Three. It compared family law legislation and decision-making with child protection legislation and decision-making to show that the evidence suggests that parents with a mental illness are treated even more unfairly by the family law system where 'potential risk' is commonly interpreted to mean unacceptable risk, and 'unacceptable risk' is generally interpreted to mean 'mental illness'.

This chapter is important to this thesis because it presents an option for positive change. It reviews the literature related to attitudinal change and identifies that the best outcomes have been achieved through short term structured programs that combine specific education and contact stratagems and that are directed toward the young person demographic. It then discusses the MHTRS, a program which it is suggested, meets the criteria identified for maximum effectiveness in positively changing attitudes. Since 2003, the MHTRS has provided mental health skills and awareness training for University of Tasmania law students who are then able to effectively represent clients appearing before the Tasmanian Mental Health Tribunal (MHT) on civil commitment and compulsory treatment matters. Details of the scheme's objectives and training programs are provided in Appendices 4, 5 and 6 at the end of the thesis.

The MHTRS has had a significant impact on Tasmania's legal landscape. It has also influenced discussion and practice in other jurisdictions. In 2008, Carney wrote that '[i]n Tasmania, neither the Legal Aid Commission nor community legal centres

provide MHT representation, instead relying on student volunteers.’² In the same article he also stated that ‘Queensland Legal Aid also rarely appears in the MHT. Instead its specialised mental health unit concentrates on people charged with criminal offences appearing in the Mental Health Court’.³ While the situation has largely remained unaltered in Tasmania, Queensland implemented its own MHTRS in 2012. The Queensland scheme is based on the Tasmanian scheme. The Queensland Public Interest Clearing House (QPILCH) and Queensland universities provide the student volunteers.

This chapter is valuable as it presents the MHTRS as a potential solution to the serious problem of non-representation for parties appearing before mental health courts in many jurisdictions. One of the major issues contributing to non-representation is the financial burden attached to the provision of free legal services. The MHTRS is a cost minimal scheme that relies primarily on volunteer services. But most importantly, for the purpose of this thesis, Chapter Seven helps in the testing of the hypothesis presented in Chapter Eight that the education and training that the MHTRS volunteers receive and the contact that they have with the clients that they represent can influence their future professional practice and may contribute to the creation of a more aware, less sanist legal system.

2. CHANGING LAW STUDENTS’ ATTITUDES TOWARD MENTAL ILLNESS

In 2002, Corrigan and Watson identified three main approaches to stigma reduction in their seminal article, *Understanding the impact of stigma on people with mental illness*.⁴ In 2012, Corrigan *et al.* undertook a meta-analysis of the research published during the intervening decade for the effects that the antistigma approaches of protest or social activism, education of the public, and contact had had on reducing public stigma associated with mental illness.⁵ They found that overall, education and contact had had positive effects on reducing stigma for adults

² Terry Carney *et al.*, ‘Advocacy and Participation in Mental Health Cases: Realisable Rights Or Pipe-Dreams?’ (2008) 26 *Law in Context* 125, 130.

³ Ibid.

⁴ Patrick W Corrigan and Amy C. Watson, ‘Understanding the impact of stigma on people with mental illness’ (2002) 1 *World Psychiatry* 16.

⁵ Patrick W Corrigan *et al.*, ‘Challenging the Public Stigma of Mental Illness: A Meta-Analysis of Outcome Studies’ (2012) 63 *Psychiatric Services* 963.

and adolescents with a mental illness although contact was better than education at reducing stigma for adults. Face to face contact was the most effective form of contact. The opposite pattern was found to be the case for adolescents with education being more effective than contact⁶, a contrary result to the findings of earlier research.⁷ Although there appears to be an empirical leap frogging between contact and education for the title of ‘most effective’, both strategies have been proven to be particularly effective when applied to the 17 – 24 age demographic of university students.

2.1 Education

Education as an anti-stigma strategy evolved from the belief that the negative attitudes associated with mental illness are fuelled by ignorance⁸, which led to the global delivery of less than effective⁹ mental health factual knowledge literacy programs.¹⁰ The educational plan for reducing stigma was that educators would provide accurate diagnostic information that challenged the knowledge recipient’s prejudices and rectified inaccurate stereotypes.¹¹ Although some educational programs did report successful outcomes in reducing stigmatised attitudes,¹² concerns were raised regarding their methodologies, lack of behavioural measures, sample sizes, program content, and sustainability of attitudinal changes leading researchers to urge concern about relying on education as a mental illness stigma reduction tool.¹³

Education programs have, however, also been shown to have had unintended negative consequences.¹⁴ The biogenetic causal model’s intention of shifting onset blame away from the person, and countering culpability and choice, so that the

⁶ Ibid.

⁷ Vanessa Pinfold *et al.*, ‘Active ingredients in anti-stigma programmes in mental health’ (2005) 17 *International Review of Psychiatry* 123.

⁸ Geoffrey Wolff *et al.*, ‘Community Knowledge of Mental Illness and Reaction to Mentally Ill People’ (1996) 168 *The British Journal of Psychiatry* 191.

⁹ Robert Hayes *et al.*, ‘Stigma directed toward chronic illness is resistant to change through education and exposure’ (2002) 90 *Psychology Reporter* 1161.

¹⁰ Patrick W Corrigan *et al.*, ‘Mental illness stigma: problem of public health or social justice?’ (2005) 50 *Social Work* 363.

¹¹ Patrick W Corrigan and Jenessa R Shapiro, ‘Measuring the impact of programs that challenge the public stigma of mental illness’ (2010) 30 *Clinical Psychology Review* 907.

¹² Heather Stuart, ‘Fighting the stigma caused by mental disorders: past perspectives, present activities, and future directions’ (2008) 7 *World Psychiatry* 185.

¹³ Patrick W Corrigan, ‘How stigma interferes with mental health care’ (2004) 59 *American Psychologist* 614.

¹⁴ Caroline E Mann and Melissa J Himelein, ‘Putting the person back into psychopathology: An intervention to reduce mental illness stigma in the classroom’ (2008) 43 *Social Psychiatry and Psychiatric Epidemiology* 545.

person is no longer seen as someone responsible for their illness can actually worsen offset responsibility so that the person is seen as less responsive to treatment, permanently mentally unwell,¹⁵ and consequently, unpredictable and potentially dangerous.^{16 17} The literacy programs have also contributed to the minimisation of the impact that social and environmental factors have on mental health¹⁸ and have confused the frequency of common mental illnesses with the fair treatment of people experiencing the uncommon, severe mental illnesses.¹⁹

While the positive impact of public education programs so far appear to be limited,²⁰ there is sufficient evidence to suggest that the attitudes of young people can be improved²¹ through their participation in short courses.²² It is important, however, that the education is balanced rather than just presenting a one-sided view of the symptoms, problems, issues and all that is extreme and ‘wrong’ with the person but offer students a sense that there is also much that is whole and right about the person, and that each person is unique in their mental health experience. This may be achieved by presenting law students with an aspirational model of legal practice with social justice as its core component.²³

Social justice involves recognition that there will always be people in society who will need a significant amount of support and assistance, no matter how much treatment, coercion, encouragement, education or training they receive. Law students should be taught how to apply a therapeutic jurisprudence approach which explicitly values psychological wellbeing to their practice.²⁴ Traditional legal education has taken a dispassionate approach to the practice of law and has largely

¹⁵ Edward E Jones *et al.*, *Social Stigma: The Psychology of Marked Relationships* (W.H. Freeman, 1984).

¹⁶ Matthias C Angermeyer *et al.*, ‘Biogenetic explanations and public acceptance of mental illness: systematic review of population studies’ (2011) 199 *The British Journal of Psychiatry*, 367.

¹⁷ Edward E Jones *et al.*, *Social Stigma: The Psychology of Marked Relationships* (W.H. Freeman, 1984).

¹⁸ ‘Cosmetic anti-stigma campaigns miss the point’ (2012) 4 *North Shore Schizophrenia Advocacy Bulletin* <<http://www.northshoreschizophrenia.org/images/2012%20Feb%20Advocacy%20Bulletin.pdf>>.

¹⁹ Carolyn Shimmin, ‘Understanding stigma through a gender lens’ (2009) 11 *Canadian Women’s Health Network* 14.

²⁰ Paul E Holmes *et al.*, ‘Changing attitudes about schizophrenia’ (1999) 25 *Schizophrenia Bulletin* 447, 454.

²¹ Vanessa Pinfold *et al.*, ‘Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools’ (2003) 182 *The British Journal of Psychiatry* 342, 344.

²² Holmes *et al.*, above 20. See also James K Morrison *et al.*, ‘An attempt to change the negative, stigmatizing image of mental patients through brief re-education’ (1980) 47 *Psychological Reports* 334.

²³ Susan L Brooks, ‘Practicing (And Teaching) Therapeutic Jurisprudence: Importing Social Work Principles And Techniques Into Clinical Legal Education’ (2005) 17 *St. Thomas Law Review* 513.

²⁴ Bruce J Winick and David B Wexler ‘The Use of Therapeutic Jurisprudence in Law School Clinical Education: Transforming the Criminal Law Clinic’ (2006) 13 *Clinical Law Review* 605.

ignored the teaching of interpersonal skills.²⁵ Law schools commonly teach students to be impersonal in their professional dealings which, although it may have advantages, can also have long term negative mental health consequences for the lawyer.²⁶

Adversarialism is said to be deeply embedded in both the formal and hidden curriculums of Australian law schools and while most now teach courses that include non-adversarial processes, 'the pervasive ethos is - often unintentionally - adversarial'.²⁷ Yet, most legal conflicts are resolved through negotiation and compromise. Lawyers work toward achieving win-win conflict resolutions because many of their clients may have continuing relationships that might survive the conflict²⁸ such as disputes amongst family members and employers and employees. This is particularly the case in matters of mental health law where treating clinicians, allied health workers and families and carers are often fundamental to the future well-being of a person experiencing a mental illness.

2.2 Contact

Personal contact has shown to be a consistently effective anti stigma strategy as it dispels myths and stereotypes through direct experience.²⁹ In the absence of direct contact, a person's attitudes are influenced by cultural stereotypes conveyed through jokes, newspaper articles, and television and film dramatisations in which people experiencing mental illness are commonly portrayed as dangerous and unpredictable.³⁰ Contact exposure produces a significant tendency to revise negative beliefs, not only toward the particular individual contacted, but toward people who experience mental illness in general.³¹ Importantly for the purposes of this thesis, the literature indicates that the benefits of contact extend to professional

²⁵ Michael S King, 'Therapeutic Jurisprudence in Australia: New Directions in Courts, Legal Practice, Research and Legal Education' (2006) 15 *Journal of Judicial Administration* 129.

²⁶ Ibid.

²⁷ Molly Townes O'Brien, 'Facing down the Gladiators: Addressing Law School's Hidden Adversarial Curriculum' (2011) 37 *Monash University Law Review* 43, 43.

²⁸ Ibid 55.

²⁹ Matthias C Angermeyer and Herbert Matschinger, 'The effect of personal experience with mental illness on the attitude towards individuals suffering from mental disorders' (1996) 31 *Social Psychiatry and Psychiatric Epidemiology* 321. See also David L Penn *et al.*, 'Dispelling the stigma of schizophrenia: what sort of information is best?' (1994) 20 *Schizophrenia Bulletin* 567.

³⁰ Judith G Rabkin, Lenore Gelb and Joyce B Lazar (eds) *Attitudes Toward the Mentally Ill: Research Perspectives*, Judith G Rabkin, Determinants of Public Attitudes About Mental Illness: Summary of the Research Literature, (U.S. Department of Health and Human Services, 1980) 15-26.

³¹ Bruce G Link and Francis T. Cullen, 'Contact with the mentally ill and perceptions of how dangerous they are' (1986) 27 *Journal of Health and Social Behavior* 289.

relationships³², essential to realising the goal of effecting positive change in the legal system.

2.2.1 *Contact reduces prejudice*

Contact leads to improved attitudes and behaviour toward mental illness,³³ a widespread belief held by social scientists since the publication of Allport's 1954 contact hypothesis: increased knowledge resulting from increased contact reduces prejudice levels.³⁴ Researchers have considered it essential to include in their studies Allport's four conditions for achieving optimal outcomes - 1) the contact is between relative equals, 2) participants have common goals, 3) there is no competition between participants, and 4) the contact is auspiced by those in authority.³⁵ Pettigrew found, however, that these conditions were not, in fact, essential to achieving positive outcomes and that even contact that had not included any of Allport's key conditions still produced significant prejudice reducing outcomes.³⁶ He reasoned that instead of being necessary, Allport's conditions only acted 'as facilitating conditions that enhance the tendency for positive contact outcomes to emerge.'³⁷ Koschate suggested that rather than treating the contact conditions as an interrelated bundle of variables, they should be regarded as independent factors.³⁸

These findings are important as they help to inform contact studies between professionals and patients/clients where power imbalances in particular, do not support the likelihood of relationships that are between equals. They help to explain the successful stigma reducing outcomes achieved by programs such as the Mental Health Tribunal Representation Scheme in which university students report increased awareness of mental health issues, greater understanding of the problems faced by people experiencing mental illness, decreased levels of fear and increased levels of social acceptance after contact.

³² Patrick Corrigan *et al.*, 'Three strategies for changing attributions about severe mental illness' (2001) 27 *Schizophrenia Bulletin* 187.

³³ Graham Thornicroft, 'Reducing stigma and discrimination: Candidate interventions' (2008) 2 *International Journal of Mental Health Systems* 1.

³⁴ Gordon W Allport, *The Nature of Prejudice* (Addison-Wesley, Oxford, 1954).

³⁵ *Ibid.*

³⁶ Thomas F Pettigrew and Linda R Tropp, 'A meta-analytic test of intergroup contact theory' (2006) 90 *Journal of Personality and Social Psychology* 751, 766.

³⁷ *Ibid.*

³⁸ Miriam Koschate and Rolf van Dick, 'A multilevel test of Allport's contact conditions' (2011) 14 *Group Processes & Intergroup Relations* 769.

2.3 Retrospective and prospective assessment

Researchers have predominately used two methods, retrospective and prospective, to study the impact of contact on stigma associated with mental illness, finding that in both methods both direct and indirect contact has proved successful³⁹ although direct social contact appears to be the most effective approach of the two.⁴⁰ The retrospective approach asks participants to report on their prior contact with people experiencing a mental illness with the responses assessed for correlation with variables such as dangerousness⁴¹ and social distance.⁴² Although many retrospective studies found that previous contact significantly lessened perceived dangerousness and the desire for increased social distance, other studies reported non-significant findings⁴³ which may be explained by the involuntariness of the prior contact.⁴⁴

There are also concerns that retrospective self reporting measures or interviews are methods that give rise to the uncertainty as to whether the self reporting is biased in a socially desirable direction that only suggests the appearance of true change and whether people whose attitudes are adjusted positively, also adjust their behaviours.⁴⁵ This study has taken the prospective approach as this is the more pertinent approach to changing attitudes and behaviours of law students through their direct contact with people experiencing a mental illness while participating in training and representation programs while at university.

2.3.1 Prospective assessment

The prospective approach differs from the retrospective approach because it does not ask participants about prior exposure, instead asking them to have contact with people experiencing mental illness as a part of the present research. Early studies using university student participants found that their attitudes and behaviours were

³⁹ Sarah Clement *et al.*, 'Filmed v. live social contact interventions to reduce stigma: randomised controlled trial' (2012) 201 *British Journal of Psychiatry* 57.

⁴⁰ Rebecca R Reinke *et al.*, 'Examining two aspects of contact on the stigma of mental illness' (2004) 23 *Journal of Social and Clinical Psychology* 377.

⁴¹ Link and Cullen, above n 31.

⁴² Sangjun Moon *et al.*, 'Factors affecting social distance toward mental illness: a nationwide telephone survey in Korea' (2000) 41 *Preventive Medicine & Public Health* 419.

⁴³ Holmes *et al.*, above n 20.

⁴⁴ Patrick Callaghan *et al.*, 'Attitudes toward mental illness: Testing the contact hypothesis among Chinese student nurses in Hong Kong' (1997) 26 *Journal of Advanced Nursing* 33.

⁴⁵ Monika E Kolodziej and Blair T Johnson, 'Interpersonal Contact and Acceptance of Persons With Psychiatric Disorders: A Research Synthesis' (1996) 64 *Journal of Consulting and Clinical Psychology* 1387.

significantly improved after they had participated in volunteer programs in mental health hospitals.⁴⁶ Hochberg recruited university students to spend an hour a week for an academic year with chronically ill patients in a hospital setting. Anecdotally, he reported that the students found their participation was an intellectual and emotional experience and it had led to increased tolerance, self acceptance, a greater sense of social responsibility and changed personalities.⁴⁷

Similarly, Chinsky and Rappaport found that their student volunteers had gained '[s]ignificantly more favorable attitudes toward "mental patients"' and had increasingly seen the patients as 'real, sometimes warm, and even likable people', in contrast to many of the student's previously held stereotypical beliefs.⁴⁸ In Kish and Hood's study, after having spent 10 weeks in voluntary contact with patients, considerable improvement was recorded in the stereotypical attitudes of students that included rating the patients as significantly less dangerous as they had believed them to be prior to contact.⁴⁹ Penny's study showed that student ideas about mental health could be changed through positive fieldwork experiences.⁵¹

Contact can reduce feelings of anxiety and fear.⁵² There appears to be a significant correlation between anxiety reduction and empathy and knowledge, suggesting that there is a causal sequence operating which implies that initial anxiety must be reduced first through contact before increased empathy, perspective taking, and knowledge can effectively contribute to prejudice reduction.⁵³ This pattern of positive contact-linked change persists across a variety of samples, settings, and with various durations of contact.⁵⁴ Contact not only produces meaningful

⁴⁶ Karl E Scheibe, 'College students spend eight weeks in mental hospital: A case report' (1965) 2 *Psychotherapy: Theory, Research and Practice* 117.

⁴⁷ Jules D Hochberg, 'The companion program: Implementing the manpower recommendations of the joint commission on mental illness and health' (1963) 18 *American Psychologist* 224, 226.

⁴⁸ Jack M Chinsky and Julian M Rappaport, 'Attitude change in college students and chronic patients: A dual perspective' (1970) 35 *Journal of Consulting and Clinical Psychology* 388, 392.

⁴⁹ Ibid.

⁵⁰ George B Kish and Rosa-Weller Hood, 'Voluntary activity promotes more realistic conceptions of the mentally ill by college students' (1974) 2 *Journal of Community Psychology* 30.

⁵¹ Neil Penny, Jack Kasar and Tony Sinay, 'Student attitudes toward persons with mental illness: The influence of course work and level II fieldwork' (2000) 55 *The American Journal of Occupational Therapy* 217.

⁵² Stefania Paolini *et al.*, 'Effects of direct and indirect cross-group friendships on judgments of Catholics and Protestants in Northern Ireland: The mediating role of an anxiety-reductive mechanism' (2004) 30 *Personality and Social Psychology Bulletin* 770. See also Irene V Blair, Bernadette Park and Jonathan Bachelor, 'Understanding intergroup anxiety: Are some people more anxious than others?' (2003) 6 *Group Processes and Intergroup Relations* 151.

⁵³ Thomas F Pettigrew and Linda R Tropp, 'How does intergroup contact reduce prejudice? Meta-analytic tests of three mediators?' (2008) 38 *European Journal of Social Psychology* 922, 930.

⁵⁴ Kolodziej and Johnson, above n 45.

reductions in prejudice, and more favourable attitudes toward the participants in the immediate contact situation, e.g. the patients in the mental health ward, it also has the same positive impact in reducing prejudice and improving attitudes about mental illness generally, and toward everyone who experiences a mental illness.⁵⁵

2.4 Structured contact

Contact intervention appears to be especially effective when included as part of the training of undergraduate students⁵⁶ but the contact needs to be structured and guided as structured contact has achieved higher positive results than situations in which contact was unstructured.⁵⁷ Structured contact that is misguided can present people experiencing a mental illness as ‘patients’ who are ‘passive victims of fate’.⁵⁸ In this type of situation, the focus is on the person’s problems, deficiencies and distress which can reinforce negative stereotypes and evoke aversion and fear.⁵⁹ It is ‘necessary to specifically tailor the classroom instruction in order to avoid increasing negative attitudes.’⁶⁰ As Perlin states when referring to the pernicious impact of bias and stereotypes associated with mental illness, ‘[l]aw teachers are not immune. Left-leaning law teachers are not immune. Clinical teachers are not immune.’⁶¹ It is important that a clinical legal program’s syllabus, and its teachers/supervisors, guide students beyond simply gaining valuable practical legal skills and experience but also achieving positive attitudinal and behavioural changes via non-sanist education and personal contact.

2.5 Voluntariness

A number of studies have strongly suggested that in order for contact to be beneficial and effect positive attitudinal change, it must be voluntary.⁶²

⁵⁵ Thomas F Pettigrew, ‘Secondary transfer effect of contact: Do intergroup contact effects spread to noncontacted outgroups?’ (2009) 40 *Social Psychology* 55. See also Thomas F Pettigrew and Linda R Tropp, ‘A meta-analytic test of intergroup contact theory’ (2006) 90 *Journal of Personality and Social Psychology* 751.

⁵⁶ Kolodziej and Johnson, above n 45.

⁵⁷ Pettigrew and Tropp, above n 36.

⁵⁸ Beatrice A Wright, ‘Developing constructive views of life with a disability’ (1980) 41 *Rehabilitation Literature* 274, 275.

⁵⁹ Mike Lyons and Robyn Hayes, ‘Student Perceptions of Persons With Psychiatric and Other Disorders’ (1993) 47 *The American Journal of Occupational Therapy* 541.

⁶⁰ Helene S Wallach, ‘Changes in attitudes toward mental illness following exposure’ (2004) 40 *Community Mental Health Journal* 235, 247.

⁶¹ Michael L Perlin, ‘They Keep It All Hid: The Ghettoization of Mental Disability Law and Its Implications for Legal Education’ (2010) 54 *St. Louis University Law Journal* 857, 861.

⁶² Wallach, above n 60. See also Neil Penny, Jack Kasar and Tony Sinay, ‘Student attitudes toward persons with mental illness: The influence of course work and level II fieldwork’ (2000) 55 *The American Journal of*

Voluntariness was a key factor in Wallach's study in which the student participants could decide to volunteer to work with the patients or simply visit them. She found that the group who volunteered to work with the mental health patients as compared to the group, who chose only to visit them, demonstrated a significant positive change in attitudes while the attitudes of the visiting group did not show similar improvement.

Link and Cullen reasoned that this link between benefit and voluntariness might be explained by the volunteer's pre-existing positive attitudes towards mental illness which prompted them to seek out the contact in the first place. However, their study found that there was no discernible difference between the more voluntary groups (contact that is likely to be chosen - a decision is made to work, volunteer or associate with people who have a mental illness) and less voluntary contact groups (contact that is unlikely to be chosen – where contact is with a family member, friend or work colleague who has a mental illness), supporting their notion that contact itself has a causative role in the contact–stigma relationship.⁶³ It is contact that 'reduces perceptions of dangerousness rather than the reverse, since several different types of contact that are unlikely to be chosen are related to lower levels of fear.'⁶⁴

2.6 Length of contact

Link and Cullen suggested that the more contact a person had with someone experiencing a mental illness, even if it was not intimate contact, significantly reduced the fear they felt toward people experiencing mental illness generally. This suggested to them that attitudes can potentially be changed if opportunities to become familiar with people experiencing mental illness are increased.⁶⁵

Occupational Therapy 217. See also Annie Rousseau and Anton F De Man, 'Authoritarian and socially restrictive attitudes toward mental patients in mental health volunteers and nonvolunteers' (1998) 83 *Psychological Reports* 803. Also Patrick Callaghan *et al.*, 'Attitudes toward mental illness: Testing the contact hypothesis among Chinese student nurses in Hong Kong' (1997) 26 *Journal of Advanced Nursing* 33.

⁶³ Link and Cullen, above n 31.

⁶⁴ *Ibid* 296.

⁶⁵ *Ibid*.

However,⁶⁶ Lyons and Ziviani found that if the length of contact time is too short, students are not able to acclimate to the setting and overcome their anxiety.⁶⁷

Wallach concluded that the influence of exposure on attitudes was not linear, and that while extensive experience was shown to be beneficial in changing attitudes, limited experience such as a 'visit to a mental health institution in addition to classroom instruction or classroom instruction alone, was harmful not only when compared to extensive experience, but even when compared to a no exposure group'.⁶⁸ On the other hand, Schwartz's findings did not support the contact hypothesis that contact is related to attitudes and contact reduces stereotyping and discrimination, instead suggesting that it was the type and situational factors of the contact which were more important than the dichotomous measure of 'some contact' as opposed to 'no contact'.⁶⁹ However, Corrigan's recent study demonstrated that contrary to these earlier study findings, in the 10-24 age group both education and contact are effective in changing attitudes, with education being the more effective of the two.⁷⁰

What is clear in the literature is that personal contact with people experiencing mental illness, and the receipt of thoughtful education, either delivered in combination or on its own, does reduce stigma and decrease prejudice among university students. The evidence suggests that undergraduates who have volunteered to participate in structured and guided programs have undergone a positive attitudinal change, which supports the view that participation in clinical programs similar to the Mental Health Tribunal Representation Scheme presents the best opportunity for positively changing the attitudes of law students, and hopefully, ultimately, the legal system.

⁶⁶ Wallach, above n 60. See also Laurel A Alexander and Bruce G Link, 'The impact of contact on stigmatizing attitudes toward people with mental illness' (2003) 12 *Journal of Mental Health* 271.

⁶⁷ Michael Lyons and Jenny Ziviani, 'Stereotypes, Stigma, and Mental Illness: Learning From Fieldwork Experiences' (1995) 49 *The American Journal of Occupational Therapy* 1002.

⁶⁸ Wallach, above n 60, 245.

⁶⁹ Chaya Schwartz and Rinat Armony-Siva, 'Students' Attitudes to the Inclusion of People with Disabilities in the Community' (2001) 16 *Disability & Society* 403.

⁷⁰ Corrigan *et al.*, above n 5.

3. THE MENTAL HEALTH TRIBUNAL REPRESENTATION SCHEME (MHTRS)

The MHTRS is a Tasmanian initiative implemented in 2003 to offer free, competent representation to all persons appearing before the Tasmanian Mental Health Tribunal (MHT). The scheme was created, developed, implemented, and in its first two years, administered by the author of this thesis. Its inception was as a direct response to the social, political and legal failure to ensure that the legislative right to be represented before the MHT in Tasmania⁷¹ could be exercised by people experiencing mental illness at a time when their basic rights and freedoms were at issue. The scheme is funded by the Department of Health and Human Services' Mental Health Services and is administered by Advocacy Tasmania Inc. (ATI), a non-government disability and aged care advocacy organisation, in collaboration with the MHT and the University of Tasmania Law Faculty.

The idea for MHTRS representation emerged in 2000. The new president of the MHT wrote to the author who, at the time, was Tasmania's first and only mental health advocate. The advocate's role was specifically created in 1998 by the then Minister of Health, Hon. Judy Jackson, to represent the patient's rights and interests was safeguarded during the closure of Royal Derwent Hospital, Australia's oldest mental asylum. In 1999, the position was broadened to a state-wide role. The president inquired whether the advocate's new role included representing patients who appeared before the tribunal. She advised that almost 100% of patients appeared unrepresented. This was a legal failing and a human rights breach according to the president. The large number of hearings that were held across the three regions of Tasmania each year made it impossible for her to include a fair and equitable tribunal representational service within her already demanding workload. Instead, she made MHT non-representation her primary systemic issue.

For the next two years, the mental health advocate unsuccessfully lobbied Legal Aid and the Department of Health and Human Services. Eventually, she decided with the support of ATI to develop a scheme that used a trained law student volunteer force. She set about strategically planning the scheme, building relationships and forming agreements with the MHT, the government and the

⁷¹ *Mental Health Act 1996 (Tas)* s 54.

UTAS Law Faculty. She recruited legal mentors. She worked to gain the support of what was initially, a very suspicious group of mental health professionals. She obtained government seed funding for a pilot project in Hobart, developed a training program and published a training manual, and recruited volunteers from the law school. In August 2003, seventy three law students attended the first training session. Sixty nine students completed this first phase of the training and received a Certificate in Skills and Awareness in Mental Health. Students could then continue on to participated in the second phase of the training. The numbers for entry into the second phase representation training was limited to 30 final year students.

The first clients were represented at a MHT hearing by trained volunteer law students in December, 2003. During the following two years, the scheme gained full funding, employed a qualified legal coordinator, expanded to a state-wide service, and was added as a compulsory module to the curriculum of the Tasmanian Legal Practice Course. In the 11 years since its inception, well over 1000 Tasmanian lawyers and future lawyers have participated in the scheme.⁷² They have gained an appreciation of the barriers facing people with mental illness and of their social obligation to help remove those barriers. By 2010,

...the Tribunal has considerably exceeded the performance of like bodies in other Australian jurisdictions. In Tasmania 64% of patients attended their hearing compared to the 50% achieved in other jurisdictions.⁷³ 79% of patients received advice from an advocate prior to appearing, well exceeding the 4.3% in Victoria.⁷⁴ This level of advocacy has been achieved in no small measure as a result of the Tribunal's continued championing of the Mental Health Representation Scheme.

Tasmanian Mental Health Tribunal Annual Report, 2009/10, 8-9.

In the year under review 52% of persons appearing before the Tribunal were represented by an advocate from the Mental Health Representation Scheme and 78.5% had been given advice and support, via the telephone, prior to hearing. The level of representation in hearings continues to rise.

Tasmanian Mental Health Tribunal Annual Report, 2009/10, 19-20.

⁷² Interview with Diane Sharman, MHTRS Coordinator, (Hobart, June, 2012).

⁷³ Annual Report Mental Health Review Board of Victoria 2009/10, Annual Report Queensland Mental Health Review Tribunal 2008/9

⁷⁴ Annual Report Mental Health Review Board of Victoria 2009/10

4. LEGAL REPRESENTATION BEFORE THE MHT

Mental health law has made a significant contribution to the development of non-adversarial justice in Australia. For the past forty years, mental health tribunals and boards of review have dealt with issues of adversarialism, legal formality and legal representation as matters of daily practice.⁷⁵ In particular, the issue of legal representation has caused consternation and debate. There is plenty of research to suggest that represented people feel empowered; less intimidated by the legal process, more informed and listened to, and feel that they have someone who is on their side.⁷⁶ One recent study found that the contact and support a person had from their legal representative could have a positive impact on their tribunal experience, particularly their acceptance of, and satisfaction with, the hearing outcomes.⁷⁷ Representation can have a therapeutic impact by increasing the perception of the overall tribunal experience for the client as being one that is fair and participatory.

On the other hand, there is research that is highly critical of legal representation, suggesting that in fact, it can produce anti-therapeutic outcomes.⁷⁸ One study indicated that 36% of represented people were less than satisfied with their legal representation⁷⁹ while another study found that legal representatives and medical professionals in guardianship hearings formed alliances.⁸⁰ This had the potential of alienating clients who perceived their lawyer as just another member of the mental health team.⁸¹ An analysis of the research shows that it is not the fact of having a representative but the type and quality of the representation that is crucial to whether a therapeutic or anti-therapeutic outcome is achieved.⁸²

⁷⁵ Penelope Weller, 'Taking a Reflexive Turn: Non-Adversarial Justice and Mental Health Review Tribunals' (2011) 37 *Monash University Law Review* 81, 82.

⁷⁶ Valerie Williams, 'The Challenge for Australian Jurisdictions to Guarantee Free Qualified Representation Before Mental Health Tribunals and Boards of Review: Learning from the Tasmanian Experience' (2009) 16 *Psychiatry, Psychology and Law* 108.

⁷⁷ Rosie McLeod *et al.*, 'Court experience of adults with mental health conditions, learning disabilities and limited mental capacity' (Report No 2, Ministry of Justice Research Series, 9 – 10 July 2010).

⁷⁸ Terry Carney *et al.*, 'Mental Health Tribunals: 'TJ' Implications of Weighing Fairness, Freedom, Protection and Treatment' (2007) 17, *Journal of Judicial Administration* 46.

⁷⁹ Mairead Dolan, Robert Gibb and Placid Coorey, 'Mental health review tribunals: A survey of special hospital patients' opinions' (1999) 10 *Journal of Forensic Psychiatry* 264, 268.

⁸⁰ Anne K Vittoria, 'The Elderly Guardianship Hearing: A socio-legal encounter' (1992) 6 *Journal of Aging Studies* 165.

⁸¹ David Tait, 'The Ritual Environment of the Mental Health Tribunal Hearings: Inquiries and reflections' (2003) 10 *Psychiatry, Psychology and the Law* 91.

⁸² Bruce J Winick, 'Therapeutic Jurisprudence and the Civil Commitment Hearing' (1999) 10 *Journal of Contemporary Legal Issues* 37.

In 2006, the President of the Tasmanian MHT presented a paper to the 3rd International Conference on Therapeutic Jurisprudence titled *Tasmanian Mental Health Representation Project – A Practical Example of Therapeutic Jurisprudence*.⁸³ In it she asked whether legal representation was in the best interests of patients appearing before the tribunal if their lawyer had no training in mental health representation. It was her experience, that lawyers without training conducted mental health tribunal proceedings as adversarial contests between the psychiatrist and patient, quoted irrelevant case law, and cross-examined psychiatrists and family members. She perceived that they believed that their role was to get the order revoked and liberate the patient from the hospital. They gave no regard to the patient's welfare in the community, their current mental state, their ability to be able to properly instruct, or to the potential that the adversarial style of questioning would break down the patient's 'necessary' relationships with their treating teams, and their families.⁸⁴ Detailing just one of a number of strikingly similar occasions to which she referred, she gave an example of the lasting problems that were caused to the patient, their family, and to the clinical staff. 'The consultant psychiatrist was "shell shocked" and refused to attend another Tribunal hearing unless, she too, was represented by a lawyer'.⁸⁵

After describing the creation, training and practices of the Tasmanian MHTRS, the President concluded that prior to 2003, Tasmanian patients detained in psychiatric hospitals and deprived of their freedoms, did not have access to justice. As they could rarely afford legal representation they appeared unrepresented before the Tribunal. The rare few with means 'were in many ways still denied access to justice' because Tasmanian lawyers had no training in mental health issues 'and were unskilled in coping with the difficulties that arose as a result of dealing with a client who had, at the time of the hearing, limited capacity to understand the nature of the hearing or a distorted view of reality'.⁸⁶ The MHTRS, however, 'supplied

⁸³ Debra Rigby, 'Tasmanian Health Representation Project – A Practical Example of Therapeutic Jurisprudence' (Paper presented at 3rd International Conference on Therapeutic Jurisprudence, Perth Western Australia, 7-9 June 2006).

⁸⁴ Ibid 4.

⁸⁵ Ibid 5.

⁸⁶ Ibid 9.

trained advocates with skills in mental health issues, at no cost, to all patients appearing before the Tribunal’⁸⁷ and at minimal cost to the government.

4.1 The right to representation before the MHT

The right to legal representation is a fundamental right for any person whose liberty is at risk.⁸⁸ It is a right reinforced by the European Court of Human Rights.⁸⁹ In *Li Shi Ping v Minister for Immigration, Local Government and Ethnic Affairs*⁹⁰, it was stated that if a person affected by an administrative decision lacked the capacity to represent themselves, the right to legal representation is an element of natural justice. The right to representation is enshrined in Principle 18(1) of the United Nations’ *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*. The Principles define the person’s entitlement to ‘counsel’ to mean ‘a legal or other qualified representative’ and that counsel shall be made available without payment if the person lacks sufficient means to pay.⁹¹

Australian mental health statutes have generally taken a flexible approach to representation with most state mental health acts authorising representation as a right. A 2008 review of Australia’s statutory requirements by this author showed that there was quite a lot of variation across states as to who could provide representation before a tribunal or board of review.⁹² Revisiting the provisions five years later shows that there have been a number of amendments in mental health acts that indicate that a legislative shift toward increased support for representation by non-legal representatives has occurred.

Section 26 (3) of the reformed Victorian Act replicated the previous s.6 (3) in which no reference was made specifically to legal representation, stating broadly that patients may be represented by any person they authorise to do so.⁹³ The previous South Australian Act had restricted representation to legal practitioners⁹⁴ but this position was reversed in the new Act which now allows representation by a legal

⁸⁷ Ibid.

⁸⁸ *Gideon v Wainwright* (1963) 372 US 335, 345 (Black J).

⁸⁹ *LM v Latvia* [2011] ECHR, Application No 26000/02, 19 July 2011.

⁹⁰ *Li Shi Ping v Minister for Immigration, Local Government and Ethnic Affairs* (1994) 35 ALD 557.

⁹¹ *United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, GA Res 46/119, 75th plen mtg, UN Doc A/RES/46/119 (17 December 1991).

⁹² Williams, above n 76.

⁹³ *Mental Health Act 1986* (Vic).

⁹⁴ *Mental Health Act 1993* (SA) s 27.

practitioner or ‘by any other person.’⁹⁵ The Western Australian,⁹⁶ New South Wales⁹⁷ and Queensland⁹⁸ Acts all allow representation by a lawyer, or with the board or tribunal’s leave, any other person. Similarly, the Northern Territory allows representation by ‘a legal practitioner or other person’⁹⁹ although leave of the tribunal is not required. The Australian Capital Territory Act merely simplified the language of the provision in its old Act which authorised representation by ‘an agent or a legal practitioner’.¹⁰⁰ This was changed in the new Act to the plainer, ‘by a lawyer or someone else.’¹⁰¹ Although the previous Tasmanian Act referred to representation by ‘a legal practitioner or other person’,¹⁰² the new Mental Health Act 2013 legislatively acknowledges the role of the trained volunteers of the state’s 11 year old MHTRS by the inclusion of a third term, ‘advocate’.¹⁰³

What the research shows is that in the past decade, the statutory requirements authorising representation before mental health tribunals and boards of review in Australia have broadened out, and away from, legal practitioner representation. In doing so, however, every Australian jurisdiction has chosen to ignore the Principle 18(1) requirement that people who appear before mental health tribunals should do so represented by a legal, or other ‘qualified’ representative.

4.2 Qualified representation

The ordinary meaning for a ‘qualified person’ is someone who has the abilities, qualities, attributes or meets the proper training and competency standards for an office or position, or to perform a particular job or task.¹⁰⁴ For example, if a home is to be rewired, to satisfy the legal requirement, a qualified electrician is engaged. The quality of the work and particularly, the safety of the work, are better ensured if the worker has the proper training and experience. An unqualified worker would not be knowingly contracted based solely on their caring or empathetic connection to the home owner. Yet, despite human rights dictates, most Australian jurisdictions

⁹⁵ *Mental Health Act 2009* (SA) s 84(4).

⁹⁶ *Mental Health Act 1996* (WA) Schedule 2 s 3(1)(b).

⁹⁷ *Mental Health Act 2000* (NSW) s 154(3).

⁹⁸ *Mental Health Act 2000* (Qld) s 450(2).

⁹⁹ *Mental Health and Related Services Act 2009* (NT) s 131(1).

¹⁰⁰ *Mental Health (Treatment and Care) Act 1994* (ACT) s 89(3).

¹⁰¹ *Civil and Administrative Tribunal Act 2008* (ACT) s 30.

¹⁰² *Mental Health Act* (1996) (Tas) s 57 (3).

¹⁰³ *Mental Health Act 2013* (Tas) sch 4 Part 2 s 7(3).

¹⁰⁴ Collins English Dictionary, <http://www.collinsdictionary.com/dictionary/english/qualified> accessed 20 May, 2013.

discourage qualified representation for vulnerable people appearing before a mental health tribunal or board of review.¹⁰⁵

Instead, tribunals and boards encourage unqualified people to represent people at a time when the serious issues before the decision-makers include the possible deprivation of their liberty for significant periods of time, a breach of their bodily integrity, their forcible treatment, and the removal of their right to autonomous lifestyle decision-making.¹⁰⁶ There are no Australian mental health laws that require that the representative should be measured against an appropriate standard of skills and knowledge, for example, knowing the relevant provisions of the Act, being aware of available community supports and options, understanding ethical responsibilities, and possessing good communication and advocacy skills which do not harm the person's important relationships with their treating professionals, families and service providers.

Weller suggests that the mental health decision-making structure seems to have assumed that the multi-disciplinary composition of tribunals and boards of review, in conjunction with informal supports, 'obviates the need for formal legal representation and is consistent with the alternative dispute resolution principles of individual empowerment and the concern to ensure that cost burdens do not limit access to justice'.¹⁰⁷ There is a marked difference, however, between the benefits that a highly vulnerable person experiencing a serious mental illness gains from having an unqualified, inexperienced person providing information and advice, support and comfort at a hearing and the benefits gained from a trained representative clearly articulating their client's legal rights and interests within a non-adversarial, therapeutic jurisprudence model of representation.¹⁰⁸

The debate should not be about whether the representative is a legal practitioner or a lay advocate but about whether the legal practitioner or lay representative who is appearing before the tribunal or board on behalf of their client is competent to properly represent the person's rights, needs and interests in a non-adversarial,

¹⁰⁵ Alfred Allan, 'The Past, Present and Future of Mental Health Law: A Therapeutic Jurisprudence Analysis' (2003) 20 *Law in Context* 24.

¹⁰⁶ The Mental Health Review Tribunal, New South Wales Government, *The Tribunal* (21 February 2013) <<http://www.mhrt.nsw.gov.au/>>.

¹⁰⁷ Weller, above n 75, 96.

¹⁰⁸ Williams, above n 76.

therapeutic forum. In Western Australia for example, the Council of Official Visitors presently provides the majority of the small number of representations that occur before the Mental Health Review Board. Visitors are appointed from the general community as having an interest in mental health. The Visitor who wishes to provide representation in a hearing receives in-house training from the Council Head, who is a lawyer, and additional outsourced training from the Mental Health Law Centre.¹⁰⁹ It is this training that provides them with qualifications that many lawyers do not possess. This representation model is worth funding consideration by governments that are failing in their international obligation to provide free representation to individuals appearing before mental health tribunals and boards of review. It draws from a committed, aware and trained pool of lay advocates.

4.3 Cost of representation

There is a wealth of research that shows that people who experience mental illness commonly have low levels of income¹¹⁰ and are, therefore, less likely to be able to afford private legal representation,¹¹¹ and are most often dependent on the services that they receive from Legal Aid and community legal centres. The limited availability of funded legal services presents an access barrier for the disadvantaged that often places them in a position where they are unable to assert or defend their legal rights.¹¹² Although the purpose of legal aid is to ensure access to legal representation for those people who cannot afford it, tight eligibility criteria have made it impossible for everyone who is in need of funding support to receive it. Funding applicants must satisfy a three tier eligibility criteria: (1) a financial means test; (2) a merit test; and (3) their legal problem must be a type of case that qualifies for financial support.¹¹³ Legal aid centres view these gate-keeping eligibility criteria as an organisational necessity due to severe under-funding, budget blow outs,

¹⁰⁹ Interview with Debora Colvin, Head of the Council of Official Visitors (Telephone Interview 20 February 2013).

¹¹⁰ Prue Cameron and Jo Flanagan, 'Thin Ice: Living With Serious Mental Illness and Poverty in Tasmania' (Report, Social Action and Research Centre, Anglicare Tasmania, May 2004) 10.

¹¹¹ Maria Karras *et al.*, 'On The Edge Of Justice: Access To Justice And Legal Needs' (Report, Volume 4, Law And Justice Foundation Of New South Wales, May 2006) <[http://www.lawfoundation.net.au/ljf/site/articleIDs/CB05FD97AAF2458CCA25718E00014293/\\$file/EdgeOfJustice.pdf](http://www.lawfoundation.net.au/ljf/site/articleIDs/CB05FD97AAF2458CCA25718E00014293/$file/EdgeOfJustice.pdf)>.

¹¹² Senate Legal and Constitutional Affairs Reference Committee, *Access to Justice*, December 2009, 30.

¹¹³ Richard Denniss, Josh Fear and Emily Millane, 'Justice for all: Giving Australians greater access to the legal system' (Institute Paper No 8, The Australian Institute, 8 March 2012) <<https://www.tai.org.au/file.php?file=.../IP8%20Justice%20for%20all.pdf>>.

under-resourcing,¹¹⁴ and overwhelming workloads.¹¹⁵ Increasingly, fewer grants of aid are provided each year.¹¹⁶

In 2004, the Law Council of Australia claimed that the consequence of the insufficient levels of public funding was that, progressively, more and more disadvantaged Australians were being prevented from accessing the justice system.¹¹⁷ The Council reported that legal aid fees were below the real cost of providing legal services; that there had been a significant withdrawal of experienced lawyers from publicly funded legal work;¹¹⁸ and that there had been some diminution in the quality of publicly funded legal representation.¹¹⁹ The 2012 *Justice for All* research paper found that these problems had not improved but had, in fact, worsened and that ‘the current legal aid funding model is inadequate and unjust.’¹²⁰

Similar problems plague Australia’s community legal centres (CLC). The Australian Council of Social Services reported that CLCs are under-resourced compared to other community sector providers.¹²¹ It estimated that that in 2007, 72% of eligible people who had sought assistance from CLCs were turned away because the centres’ services were operating at maximum capacity.¹²² In an attempt to manage the persistent funding and resourcing deficits, CLCs have applied informal, widely unacknowledged filters on the work that they are prepared to undertake.¹²³ They have tended to ‘focus on providing legal assistance and advice

¹¹⁴ Hugh de Krestor, ‘Frontline aid needs funding lifeline’, *The Australian* (online), 1 February 2013 <<http://www.theaustralian.com.au/business/legal-affairs/frontline-aid-needs-funding-lifeline/story-e6frg97x-1226566254383>>.

¹¹⁵ Louis Andrews, ‘Legal Aid calls for funding increase’, *The Canberra Times* (online), 5 October 2012 <<http://www.canberratimes.com.au/act-news/legal-aid-calls-for-funding-increase-20121004-272n0.html>>.

¹¹⁶ Ibid.

¹¹⁷ Law Council of Australia and the Australian Institute of Judicial Administration National Legal Aid, ‘Erosion of Legal Representation in the Australian Justice System’ (Report, Law Council of Australia and the Australian Institute of Judicial Administration National Legal Aid, February 2004) <<http://www1.lawcouncil.asn.au/lawcouncil/images/LCA-PDF/a-z-docs/fmsdownload079a.pdf>>.

¹¹⁸ Don Fleming and Anne Daly, ‘The retreat of the legal profession from legal aid: labour market change in the Australian mixed model’ (2007) 14 *International Journal of the Legal Profession* 21.

¹¹⁹ Law Council of Australia and the Australian Institute of Judicial Administration National Legal Aid, above n 115.

¹²⁰ Denniss, Fear and Millane, above n 113, 10.

¹²¹ Australian Council of Social Service, ‘Are you being served: indicators for capacity building of community sector services’ (Research Paper, Australian Council of Social Service, 2005).

¹²² Australian Council of Social Services, ‘Australian Community Sector Survey: 2007 National Report’ (Report, Australian Council of Social Service, February 2007) 10.

¹²³ Legal Aid Commission of New South Wales, ‘Review of the NSW Community Legal Centres Funding Program’ (Final Report, Legal Aid Commission of NSW, February 2006) 100.

and community legal education. Representation is not usually available except in cases of unusual disadvantage or if the case is in the public interest.¹²⁴

Representation before mental health tribunals is almost entirely dependent on these limited publically funded legal services. Williams showed that under the previous NSW Act, only 18.3% of people had appeared represented in hearings before the tribunal in 2003.¹²⁵ During the past decade, this statistic increased to 63%¹²⁶ although it appears that as a consequence of funding issues, this statistic is likely to significantly decrease in the coming years unless more funding is achieved, or alternative representation processes are put into effect. The tribunal reported in its 2011/12 Annual Report that representation is usually provided by the Mental Health Advocacy Service which recently advised the tribunal that due to funding restrictions it could no longer automatically provide representation.¹²⁷

In 2003, the Victorian Mental Health Review Board Annual Report stated that 9.2% of hearings had involved legal representation. A breakdown showed that it was provided by Victoria Legal Aid (68%), the Mental Health Legal Centre (18%), private lawyers (13%) and the Office of the Public Advocate (1%).¹²⁸ Almost a decade later, the representation figure has only increased by 0.2%. The board reported in its 2011/12 Annual Report that 9.4% of its clients had legal representation, a decrease on the 9.6% on the previous reporting year (2010/11) and an increase on the 4.5% reported the year prior (2009/10).

In its submission on the Draft Mental Health Bill, December 2011, the Western Australian Mental Health Law Centre (MHLC) stated that ‘At present, the legal representation rate at MHRB hearings is less than 8%. Without the provision of adequate funding for mental health advocacy services, it can be expected that this figure would drop significantly’.¹²⁹ The MHLC had also reported in 2003 that it had

¹²⁴ Karras *et al.*, above n 111.

¹²⁵ Williams, above n 76, 113.

¹²⁶ Mental Health Review Tribunal, ‘Mental Health Review Tribunal 2011/12 Annual Report’ (Report, Mental Health Review Tribunal, 2012) as required by section 147 of the *Mental Health Act 2007*, <<http://www.mhrt.nsw.gov.au/assets/files/mhrt/pdf/Annualreportfinal2012.pdf>>

¹²⁷ Annual Report of the Mental Health Review Tribunal, for the period from 1 July 2011 to 30 June 2012, as required by section 147 of the *Mental Health Act 2007*, 16 <<http://www.mhrt.nsw.gov.au/mhrt/pdf/Annualreportfinal2012.pdf>>.

¹²⁸ Mental Health Review Board of Victoria, ‘Annual Report for the year ending 30 June 2003’ (Report, Mental Health Review Board of Victoria, 13 October 2003) 33 <<http://www.mhrb.vic.gov.au/images/stories/mhrb/publications/annualreports/ar2003.pdf>>.

¹²⁹ Draft Mental Health Bill 16 December 2011, Mental Health Law Centre (WA) Inc. Submission Legal Representation At Mental Health Tribunal Hearings, 14.

represented 9.7% of people appearing before the Mental Health Review Board¹³⁰ although ten years on (2011/12), this figure had decreased to 9.3%.¹³¹ It was, however, a significant increase on the previous year's (2011/10) figure of 5.4%.¹³²

The likelihood that any funding for legal representation will be increased in Western Australia, or elsewhere, is minimal due to the poor global economic climate and the fiscal concerns experienced across all jurisdictions. But an increasingly likely reason for the failure of governments to increase funding to Legal Aid and CLCs may well be the presence of more cost effective alternative representation options. In Western Australia, the Council of Official Visitors has the authority to provide assistance before and during mental health hearings. As part of its 2003 strategic plan, the Council had decided to increase its representation by 25% in each of the following three years.¹³³ Although this was not achieved, increased representation continued to remain a strategic goal and in 2011/12 the Council reported that of the 33.2% of people who had appeared represented before the Board, 23.9% had been represented by an Official Visitor.¹³⁴

In Tasmania, the Legal Aid Commission of Tasmania had historically refused to give grants of aid for representation before the MHT. During talks with Mental Health Services in 2002, the Director indicated that the Commission would employ a mental health lawyer in the Hobart area if it received funding of \$100,000.¹³⁵ This did not occur but in 2007 the Commission did receive funding from the Department of Justice to develop and implement a representation program. Representation commenced in late 2007. In the Tribunal's Annual Report 2011/12, it stated that:

Despite the Legal Aid Commission now providing a statewide service to persons appearing before the Tribunal, the Mental Health Representation

¹³⁰ Mental Health Review Board Western Australia, 'Annual Report 2003' (Report, Mental Health Review Board Western Australia, 2003) <http://www.mhrbwa.org.au/publications/pdfs/Annual_Report_2003.pdf>.

¹³¹ Ibid.

¹³² Office of the Official Visitors Western Australia, Annual Report 2009/10' (Report, Office of the Official Visitors Western Australia, 2009/10)

¹³³ Mental Health Review Board Western Australia, 'Annual Report 2003' above n 128.

¹³⁴ Office of the Official Visitors, Western Australia, 'Annual Report 2011/12' (Report, Office of the Official Visitors Western Australia, 2011/12) <http://www.mhrbwa.org.au/publications/pdfs/Annual_Report_2012.pdf>

¹³⁵ Advocacy Tasmania Inc., 'Inquiry into Legal Aid and Access to Justice' (Submission, Advocacy Tasmania Inc., September 2003) <http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Committees?url=legcon_ctte/completed_inquiries/2002-04/legalaidjustice/submissions/sub39.doc>.

Scheme continues to represent the majority of patients. Legal Aid appeared in less than 10% of matters.¹³⁶

The creation of the Mental Health Tribunal Representation Scheme and the strategic direction taken by the Council of Official Visitors in Western Australia were in direct response to the problem of low, or non-existent, representation for one of society's most vulnerable and disadvantaged groups when its members, at times of crisis, are brought before mental health tribunals and boards of review for decisions to be made that can severely restrict their freedoms. Carney and Tait referred to the continuing problems that had given impetus to the foundation of the MHTRS when they wrote that given Australia's legal aid resource constraints, reservations about the wrong styles of mental health advocacy, and the high numbers of people with limited, or indeed any access to legal assistance,¹³⁷ '[a]dvocacy could also be broadened to include trained lay advocates, along the lines of the volunteer mainly undergraduate and postgraduate students coordinated under the Tasmanian scheme (Williams, 2009, p.118)'.¹³⁸

Sanism is a key factor in the issue of non-representation in mental health law. People who experience a mental illness are perceived as unworthy of the limited available funding dollars that are needed as desperately elsewhere. They are locked in hospitals to receive treatment and not in prison to receive punishment. They are forcibly injected or subjected to electroconvulsive therapy (ECT) to make them 'well'. Legal representation is regarded by many as unnecessary and sanism justifies their deprivation of their rights.

¹³⁶ Mental Health Tribunal Tasmania, 'Annual Report 2011 – 12' (Report, Mental Health Tribunal Tasmania 2011/2012) 16
<http://www.mentalhealthtribunal.tas.gov.au/__data/assets/pdf_file/0008/226493/Website_Copy_-_MHT_2011-12_.pdf>.

¹³⁷ Williams, above n 76. See also Fleur Beaupert, 'Mental health tribunal processes and advocacy arrangements: 'Little Wins' are No Small Feat' (2009) 16 *Psychiatry, Psychology and Law* 90. See also Terry Carney and Fleur Alleen Beaupert, 'Mental health tribunals: Rights drowning in un-"chartered" health waters' (2008) 13 *Australian Journal of Human Rights* 181.

¹³⁸ Terry Carney and David Tait, 'Mental Health Tribunals - Rights, Protection, or Treatment? Lessons from the ARC Linkage Grant Study' (2011) 18 *Psychiatry, Psychology and Law* 137, 148.

4.4 Non-adversarial representation

The adversary system assumes, in the interests of both justice and efficiency that cases will be presented to courts by skilled professionals. To the extent to which that assumption breaks down, so does the system.¹³⁹

There has been extensive discussion regarding the role and function of lawyers appearing before mental health tribunals¹⁴⁰ with a significant number of commentators claiming that the involvement of lawyers in mental health tribunal hearings inevitably results in damaging adversarial practices which cause distress to all parties; are counterproductive; and harm doctor-patient relationships.¹⁴¹ The counter position is that lawyers are necessary to mental health representation as they bring with them an intellectual rigour to the relevance and probative value of the information presented to the tribunal.¹⁴² Clients are generally judged to be more informed, feel less intimidated, and are satisfied that their views have been put to the tribunal. Lawyers are said to be able to use their problem-solving, mediation and other non-adversarial skills to good effect¹⁴³ but this interpretation presumes that the effective lawyer is someone who is knowledgeable in mental health law; practiced in non-adversarial forums; has an awareness of mental health issues; and possesses the skills necessary to achieve therapeutically beneficial outcomes for their clients. However, this is most often not the case.

4.5 Therapeutic jurisprudence

Perlin suggests that sanism and pretextuality may eventually be neutralised by therapeutic jurisprudence (TJ).¹⁴⁴ TJ as it is, somewhat affectionately, called by its proponents has been a quiet revolution in law: a part of a wider trend towards more comprehensive, participatory and psychologically optimal means of resolving

¹³⁹ The Hon. Murray Gleeson AC, Current Issues For The Australian Judiciary, Speech to Supreme Court of Japan, Tokyo - 17 January 2000, <http://www.hcourt.gov.au/assets/publications/speeches/former-justices/gleeson/cj_Japanj.htm>.

¹⁴⁰ Ian Freckelton, 'Mental Health Review Tribunal Decision-Making: A Therapeutic Jurisprudence Lens' (2003) 10 *Psychiatry, Psychology and Law* 49. See also Bruce J Winick, 'Therapeutic Jurisprudence and the Civil Commitment Hearing' (1999) 10 *Journal of Contemporary Legal Issues* 37. Also Alfred Allan, 'The Past, Present and Future of Mental Health Law: A Therapeutic Jurisprudence Analysis' (2003) 20 *Law in Context* 24.

¹⁴¹ Rigby, above n 83. See also Weller, above n 75.

Also Terry Carney and David Tait, 'Mental Health Tribunals - Rights, Protection, or Treatment? Lessons from the ARC Linkage Grant Study' (2011) 18 *Psychiatry, Psychology and Law* 137. Also Terry Carney *et al.*, 'Mental Health Tribunals: 'TJ' Implications of Weighing Fairness, Freedom, Protection and Treatment' (2007) 17, *Journal of Judicial Administration* 46. See also Stern, R.S., 'The cost of Mental Health Review Tribunals' (1994) *Psychiatric Bulletin* 18, 578. <<http://pb.rcpsych.org/content/18/9/578.1.full.pdf>>.

¹⁴² Weller, above n 75.

¹⁴³ Ibid.

¹⁴⁴ Michael L Perlin, 'A Law of Healing' (1999-2000) 68 *University of Cincinnati Law Review* 407, 409.

conflict within the legal system.¹⁴⁵ Having had its beginnings in the 1980s in the works of David Wexler and Bruce Winick, TJ is an interdisciplinary approach to the role and reform of the law that is viewed as a therapeutic agent.¹⁴⁶ It is concerned with the impact that legal processes and justice agents have upon the well-being of participants in the legal system, and the implications for attaining justice system objectives. Its claim is that the processes used by courts, lawyers and other justice agents can impede, promote or be neutral in relation to outcomes connected with participant wellbeing.¹⁴⁷

The TJ approach has particularly gained the attention of the supporters of problem-solving courts such as drug, mental health, and indigenous courts commonly conceived to resolve the underlying problems of their participants.¹⁴⁸ It has a strong practical focus and an application that borrows heavily from the behavioural sciences that have provided legal professionals with a new set of techniques that reach beyond simply deterrence and punishment.¹⁴⁹ By using these behavioural science tools to facilitate an enhanced understanding of the law and its application, antitherapeutic outcomes are minimised while therapeutic potential is maximised.¹⁵⁰ TJ offers a humanistic and psychological dimension to mental health law.

But TJ does have its critics, who claim that it is too vaguely defined and undistinctive in its content, relying instead on the therapeutic effects of particular actions.¹⁵¹ It is a descriptive and instrumental tool rather than an analytical theory.¹⁵² '[T]herapeutic jurisprudence is simply a form of consequentialism, the view that the morally best action is that one that will maximize the good.'¹⁵³ Petrila claims that TJ is paternalistic and although it uses the language of autonomy and

¹⁴⁵ Michael S King, 'Therapeutic Jurisprudence's Challenge to the Judiciary' (2011) 1 *Alaska Journal of Dispute Resolution* 1 <SSRN: <http://ssrn.com/abstract=2100632>>.

¹⁴⁶ David B Wexler and Bruce J Winick, *Essays in Therapeutic Jurisprudence* (Carolina Academic Press, 1991).

¹⁴⁷ Ibid.

¹⁴⁸ Michael S King, 'Solution-Focused Judging Bench Book' (Bench Book, Australasian Institute of Judicial Administration Incorporated, 2009) <<http://www.aija.org.au/Solution%20Focused%20BB/SFJ%20BB.pdf>> See also Justice Peggy Fulton Hora, 'Therapeutic What?' (2006) <http://www.judgehora.com/therapeutic_what.pdf>.

¹⁴⁹ David B Wexler, 'Therapeutic Jurisprudence in a Comparative Law Context' (1997) 15 *Behaviour Science and Law* 233.

¹⁵⁰ Ibid.

¹⁵¹ Christopher Slobogin, 'Therapeutic Jurisprudence: Five Dilemmas to Ponder' (1995) 1 *Psychology, Public Policy & Law* 193.

¹⁵² Valmaine Toki, 'Will Therapeutic Jurisprudence Provide a Path Forward for Maori' (2005) 13 *Waikato Law Review* 169.

¹⁵³ Ken Kress, 'Therapeutic Jurisprudence and the Resolution of Value Conflicts: What We Can Realistically Expect, in Practice, from Theory' (1999) 17 *Behavioral Sciences and the Law* 555, 558.

choice, it reinforces the existing distribution of power in the relationship between the 'treater and treated.'¹⁵⁴ He also questions who should be making decisions about what a therapeutic outcome is.¹⁵⁵ There is also criticism that TJ cannot resolve value conflicts, especially between autonomy rights and therapeutic values;¹⁵⁶ that it places a strain on court finances, time and resources; it fragments the court system; and it disregards traditional legal principles such as judicial impartiality and due process.¹⁵⁷

In response, supporters of TJ argue that it does not deserve reverence.¹⁵⁸ Ian Freckleton reflects that TJ is a problematic concept which deservedly has its critics 'from whose perceptions there is much to learn'.¹⁵⁹ TJ is a facilitator of consciousness and awareness of outcomes not a justification for simply acting 'in what someone considers a person's "best interests."'.¹⁶⁰ It does not legitimise paternalism or coercion¹⁶¹ but acknowledges that there are times where a therapeutic approach can be paternalistic rather than empowering, and discriminatory rather than right enhancing. A mental health hearing is a process of balancing values and while therapeutic interests of treatment/wellbeing should not be the dominant values, they are a justifiable part of the balancing process.¹⁶² They should sit alongside other equally important values including autonomy, integrity and public safety. The unashamed goal for therapeutic jurisprudence is to restore balance through healing.

4.5.1 The fiscal crisis

Rottman and other commentators suggest that the long-term fate of therapeutic jurisprudence in the court system is dependent on its migration from specialist courts to the larger mainstream court system, 'Otherwise they are likely to have

¹⁵⁴ John Petrila, 'Paternalism and the Unrealized Promise of Essays in Therapeutic Jurisprudence' in David B Wexler and Bruce J Winick (eds) *Law in a Therapeutic Key: Developments in Therapeutic Jurisprudence* (Durham, NC: Carolina Academic Press, 1996) 688.

¹⁵⁵ Ibid.

¹⁵⁶ Kress, above n 153, 558.

¹⁵⁷ Arthur G Christean, 'Therapeutic Jurisprudence: Embracing a Tainted Ideal' (2002) *Focus On Utah* <<http://psychrights.org/articles/TherapeuticJurisprudenceTaintedIdeal.htm>>.

¹⁵⁸ Ian Freckleton, 'Therapeutic Jurisprudence Misunderstood and Misrepresented: The Price and Risks of Influence' (2008) 30 *Thomas Jefferson Law Review* 575.

¹⁵⁹ Ibid 595.

¹⁶⁰ Ibid.

¹⁶¹ Ibid.

¹⁶² Kress, above n 153.

limited life spans and do as much harm as good.’¹⁶³ Court administrators and funding providers are becoming increasingly unwilling to fragment judicial operations, jurisdictions and resources. There is also an expectation that less adversarial problem-solving and solution-focused courts and tribunals meet higher standards and achieve better and faster outcomes, than their mainstream equivalents,¹⁶⁴ and that ‘if they prove too expensive, they will eventually lose their privileged status and will have to compete with the next ‘vogue.’¹⁶⁵

The concerns of Rottman and Freiberg are being realised as governments driven by fiscal concern claim that low success rates and high recidivism rates have necessitated the closures of problem-solving courts.¹⁶⁶ The Queensland 2012/13 State Budget, delivered on 11 September, 2012, removed all state funding from Court Diversionary Programs such as the Murri Court, Drug Court, Special Circumstances Court and Queensland Alcohol Diversion Program, and also from the Tenants Union and Tenants Advice and Advocacy Service.¹⁶⁷ The Northern Territory government reported in its 2012/13 budget that ‘Savings of \$4.2 million per year by 2014-15 will be made by disbanding the Substance Misuse and Referral for Treatment (SMART) Court, the Alcohol and Other Drugs Tribunal and the Community Court.’¹⁶⁸ And a government cost cutting measure¹⁶⁹ in 2012 resulted in the sudden closure of the Youth Drug and Alcohol Court in New South Wales.¹⁷⁰ Governments are increasingly withdrawing their funding support of legal services for marginalised and disadvantaged groups, mainstreaming the services back into the traditional legal forums and neo liberalist user pay system. They claim the

¹⁶³ David B Rottman, ‘Does Effective Therapeutic Jurisprudence Require Specialized Courts (and Do Specialized Courts Imply Specialist Judges)?’ (2000) *Court Review* 26.

¹⁶⁴ Nigel Stobbs and Geraldine Mackenzie, ‘Evaluating the Performance of Indigenous Sentencing Courts’ (2009) 13 *Australian Indigenous Law Review* 90.

¹⁶⁵ Arie Freiberg, ‘Therapeutic Jurisprudence in Australia: Paradigm Shift or Pragmatic Incrementalism?’ (2003) 20 *Law In Context* 6, 19.

¹⁶⁶ Adele Horin, ‘Youth drug court victim of budget cuts, say Salvos’, *The Sydney Morning Herald* (online), 11 July 2012 <<http://www.smh.com.au/national/youth-drug-court-victim-of-budget-cuts-say-salvos-20120710-21ty6.html>>.

¹⁶⁷ Queensland Council of Social Services, ‘QCOSS Commentary State Budget 2012-13’ (Commentary, 2013) <https://www.qcoss.org.au/sites/default/files/QCOSS_Budget_Commentary_2012-13.pdf>.

¹⁶⁸ John Elferink, Northern Territory Attorney-General and Minister For Justice, ‘Focus on Providing Core Services’ (2012 -13 Mini Budget Media Release, 4 December 2012) <<http://newsroom.nt.gov.au/index.cfm?fuseaction=printRelease&ID=10130>>.

¹⁶⁹ Horin, above n 166. See also Editorial, ‘Quiet death of the youth drug court’, *The Sydney Morning Herald* (online), 9 July 2012 <<http://www.smh.com.au/opinion/editorial/quiet-death-of-the-youth-drug-court-20120708-21p7h.html>>.

¹⁷⁰ Council of Social Services New South Wales, ‘Government’s short sighted cost-cutting trumps rehabilitation of young offenders’ (Media Release, 5 July 2012) <<http://www.ncoss.org.au/content/view/6907/98/>>.

establishment of problem-solving courts ‘were inefficient policies that focused on ‘looking good’ instead of positive results.’¹⁷¹

Although attempting to quantify feelings of well-being, integrity, and accomplishment is wrongheaded, the distribution of government dollars is inextricably connected to key performance indicators and statistical outcomes. Governments that have historically failed to fund, or to fund adequately, representation before mental health tribunals and boards of review, are unlikely in the present economic climate or into the foreseeable future, to fund expensive legal representation. Funding bodies are more likely to fund cost efficient and non-adversarial statutory and community sector schemes that use trained peer and lay volunteers. Philanthropic funding support may also be attracted to a more healing model of representation which was the case in Queensland where QPILCH achieved funding for its MHTRS which was based on the Tasmanian model. The QPILCH scheme is discussed in more detail below in Section 6.0 The topic is ripe for further research, and it is recommended that discussion should commence in earnest between governments, universities, community sector organisations and the legal system so that the issue of mental health non-representation may be eventually resolved.

4.6 Creating a TJ lawyer

Lawyers need to have ‘an understanding of basic psychological principles and psychodynamic processes as they inevitably influence and inform all human relationships: the lawyer-client relationship is no exception.’¹⁷² Recent years have seen an emergence of the therapeutic jurisprudence model of lawyering which contemplates lawyers practicing with an ethic of care and finely tuned sensitive inter and intra personal counselling skills that emphasise the prevention of legal problems.¹⁷³ While ideally lawyers should be trained in these personal skills at law school, the reality is that very few are.¹⁷⁴ Psychology and social work insights have helped lawyers to better understand their role in the mental health process as an effective lawyer. The trend toward emotional competence being an essential

¹⁷¹ Elferink, above n 168.

¹⁷² Marjorie A Silver, ‘Supporting Attorney’s Personal Skills’ (2009) 1 *Restiva Juridica Upr* 147, 148.

¹⁷³ Winick and Wexler, above n 24.

¹⁷⁴ Silver, above n 172, 157.

element for effective lawyering has not, however, been generated by traditional legal education which does little, if anything at all, to prepare law students for the psychological and emotional aspects of legal practice.¹⁷⁵

Exposure to therapeutic jurisprudence while in law school helps students to move beyond ‘black letter law’ and readies them for the complex problems, psychological and emotional pain, and distrust they will encounter in the world outside university. It can provide a ‘moral framework’ for conceptualising legal issues.¹⁷⁶ By bringing the insights across from psychology and social work, programs such as the MHTRS are able to provide law students with an ‘experiential setting that is a natural laboratory for applying therapeutic jurisprudence.’¹⁷⁷ The lawyer who practices within this broadened concept of their professional role will strive to avoid, or to minimise the psychologically damaging effect they have on their client while they seek to protect and promote their client’s rights and interests, and improve their well-being.¹⁷⁸

Therapeutic jurisprudence is committed to client centred lawyering and although lawyers may have their own opinions regarding the choices and decisions to be made in their client’s best interests, the lawyer must not act paternalistically or try to manipulate as ultimately, it is the client’s right to decide.¹⁷⁹ Law students participating in the MHTRS are taught how to interact with their clients in a non-judgmental, non- paternalistic way. They are taught to converse in a motivational manner with clients who are often being detained in an acute mental health facility. Students are provided with interdisciplinary insights to enable them to work collaboratively with the health and allied health professionals to develop successfully enhanced outcomes for their client: e.g. a community support plan or a supported housing placement. (See Appendices 4, 5 and 6)

MHTRS volunteers represent a new generation of lawyers who are being trained to more effectively represent the rights and interests of some of Australia’s most vulnerable and disadvantaged citizens. The education and skills that they learn and

¹⁷⁵ Ibid 149.

¹⁷⁶ Paul G Haskell, ‘Teaching Moral Analysis in Law School’ (1991) 66 *Notre Dame Law Review* 1025.

¹⁷⁷ Gregory Baker and Jennifer Zawid, ‘The Birth of a Therapeutic Court’s Externship Program: Hard Labor But Worth the Effort’ (2005) 17 *St. Thomas Law Review* 711, 712.

¹⁷⁸ Winick and Wexler, above n 24.

¹⁷⁹ Winick and Wexler, above n 24, 607.

practise within a therapeutic jurisprudential model of representation bring sensitivity into their practice of law. Continuing their therapeutic jurisprudence practice is likely to increase their job satisfaction, lower levels of stress, improve morale, and positively influence the public's present perception of the general decline in lawyers' values, ideals, and morals.¹⁸⁰ It may also help to reduce stigma and decrease discrimination across the legal system to the advantage of people who experience mental illness.

5. EFFECTIVE REPRESENTATION: *THE GENESEE STUDY*¹⁸¹

The United States National Center for Child Abuse and Neglect has encouraged and funded projects that explore and evaluate alternative ways of providing representation to children in civil protection matters since 1976.¹⁸² When Duquette and Ramsey undertook an empirical examination of what constituted effective representation in 1982, the dissatisfaction and uncertainty surrounding the representation and advocacy provided to children in child abuse and neglect cases was widespread. Although their study related to children, the *parens patriae* doctrine makes people experiencing mental illness subject to similar protective laws, and the problems of representation that cause concern in the area of juvenile law are exactly the same problems that cause concern in mental health law. The possible options for rectifying these problems are also the same.

Duquette and Ramsey's study took place in Genesee County U.S.A which, in 1980, had a population of 450,449. In that jurisdiction, all children in child protection matters were represented by legal practitioners who were generally recognised as having little by way of education and training that enabled them to properly serve the special interests of their clients. Duquette and Ramsey indicated that the representation problems identified in Genesee County were the same throughout

¹⁸⁰ Susan Daicoff, 'Lawyer, Know Thyself: A Review of Empirical Research on Attorney Attributes Bearing on Professionalism' (1997) 46 *American University Law Review* 1337.

¹⁸¹ Donald N Duquette and Sarah H Ramsey, 'Representation of Children in Child Abuse and Neglect Cases: An Empirical Look at what Constitutes Effective Representation' (1987) 20 *University of Michigan Journal of Law Reform* 341.

¹⁸² *Ibid* 350.

the United States. Because the lawyers had no special training, '[u]nfortunately, these attorneys tend to provide poor quality representation.'¹⁸³

Many lawyers also had little knowledge of the physical, psychological and developmental aspects of their client or of the complexities of the problems that they experienced. Few had any specialist training or expertise in working in the protective court arena. As law schools did not usually provide training in non-traditional roles and non-legal responsibilities, lawyers often felt ill-equipped and uncomfortable performing their role. Overall, Duquette and Ramsey found that legal representation was haphazard and of variable quality, with many children not receiving effective representation.¹⁸⁴

The researchers used a control group comprised of lawyers who regularly worked in child protection matters but who had had no specific training in child advocacy, and a demonstration group that was subdivided into three groups (1) lawyers, (2) law students, and (3) lay volunteers. The lawyers, law students and lay volunteers in the demonstration group participated in 12.5 hours of training before representing clients and being evaluated on performance and case outcomes. The researchers found that although there were significant differences between the control and demonstration groups in performance and outcomes, there were few significant differences among the demonstration groups of law students, lay volunteers, and trained lawyers. 'The three demonstration groups performed very much alike and achieved very similar results for their young clients.'¹⁸⁵ The researchers found that the trained non-lawyers performed as well as the trained lawyers, and better than the lawyers in the control group who had not received the special training. They also found that the lawyers who had received the training behaved differently to their untrained fellow lawyers.¹⁸⁶

The importance of these findings is that Duquette and Ramsey clearly suggest that it is the specialist training rather than the legal qualifications or legal experience that achieves effective representation. It is irrelevant whether the representative is a MHTRS law student, a Western Australian Official Visitor, or a peer advocate from

¹⁸³ Duquette and Ramsey, above n 181, 391.

¹⁸⁴ Ibid 351.

¹⁸⁵ Ibid 342.

¹⁸⁶ Ibid 390.

a community sector mental health service; if the person has been specially trained, the quality of their representation is equal to that of a specially trained lawyer and better than that of the lawyer who has not undertaken specialist mental health training.

Duquette and Ramsey advised policymakers to base their representative funding decisions on cost and availability. Using lawyers is costly, while lower costs are associated with using law students and volunteers, although selection training and supervision of the volunteers is extremely important and this could be expensive. Law students or social work or psychology students could be used but would require careful monitoring, and due to the transience of university education, regular training would be necessary. These had all been factors that had been independently considered during the development process of the MHTRS.

Because of the high quality of child representation provided by the project's lay volunteers and the potential cost savings of such volunteer programs, we recommend that other jurisdictions consider whether they could benefit from initiating programs that rely on non lawyer representation of children, under lawyer supervision, with representation provided by carefully selected and trained volunteers, such as law students, social workers, psychologists, or graduate students in those disciplines. The least expensive model of representation would utilize law students, whose training and supervision are provided by a law school without cost to the court system. This project would also help produce attorneys trained in representing children.¹⁸⁷

Thirty years after Duquette and Ramsey's recommendations, Walsh and Douglas again raised the issue of using well-trained laypeople, including law students, to represent children in child protection matters in Australia. They suggested that lawyers working in child protection should be specially trained, and where legal representation was unavailable, trained non-legal advocates should be used, which was 'something that Australian law schools could practically support.'¹⁸⁸

In protective systems, such as child protection and mental health, which are based on detailed legislation that involves questions of rights and interests, and which

¹⁸⁷ Duquette and Ramsey, above n 181, 390.

¹⁸⁸ Tamara Walsh and Heather Douglas, 'Lawyers, Advocacy And Child Protection' (2011) 35 *Melbourne University Law Review* 621, 649.

have serious consequences for people's lives, it is difficult to argue that there is no role for lawyers but it can equally be argued for the same reasons that their representation must be effective. For representation to be effective, lawyers must undertake specialist training. When effective legal representation is not available because of cost restraints, cost-effective alternatives using trained law students and volunteer lay people should be supported by the community, government, universities and particularly, the legal fraternity.

Lawyers can be monopolistic and territorial,¹⁸⁹ believing strongly in the importance of their presence and the unique skills and insights that they bring to a case and to the decision-making process.¹⁹⁰ 'Lawyers have a long-standing monopoly over the business of law, and have generally believed that this business belongs exclusively to lawyers'.¹⁹¹ To hold a monopoly, the public must be convinced that the organisation has a code of professional conduct and philosophical theories based on the notion of a service ideal and the public interest.¹⁹² For the legal profession, fulfilling the service ideal means that although it is primarily motivated by an objective altruism, it can supply 'a competent service to all at a reasonable cost'.¹⁹³ The reality is that it does not, and that it probably cannot.

'For too long, the legal profession has focused on legal aid, pro bono and charitable assistance as the solution to the crisis in access to justice. The approach is admirable, but futile'.¹⁹⁴ Many lawyers resist the incursion of law students and lay people representing clients before tribunals, boards and courts. The research suggests that this resistance is not derived from the poor quality of lay representation and is more likely an outdated territorial response. What should be of ultimate importance to all is attempting to rectify the injustice of people experiencing mental illness unable to access effective legal representation for mental health hearings. The solution seems simple as it only needs to satisfy three

¹⁸⁹ Alexandra M Ashbrook, 'The Unauthorized Practice of Law in Immigration: Examining the Propriety of Non-Lawyer Representation' (1991) 5 *Georgetown Journal of Legal Ethics* 237.

¹⁹⁰ Walsh and Douglas, above n 188, 649.

¹⁹¹ Jacqueline M Nolan-Haley, 'Lawyers, Non-Lawyers And Mediation: Rethinking The Professional Monopoly From A Problem-Solving Perspective' (2002) 7 *Harvard Negotiation Law Review* 235, 238.

¹⁹² Ibid.

¹⁹³ Harry Cohen, 'Confronting Myth in the American Legal Profession: A Territorial Perspective' (1970) 22 *Alabama Law Review* 513, 518.

¹⁹⁴ Gillian Hadfield, 'Lawyers, make room for nonlawyers' *CNN* (online) 25 November 2012 <http://edition.cnn.com/2012/11/23/opinion/hadfield-legal-profession/index.html?utm_source=twitterfeed&utm_medium=linkedin&utm_campaign=Feed%3A+rss%2Fenn_latest+%28RSS%3A+Most+Recent%29&goback=.gde_123735_member_190285594>.

requirements: (1) lawyers undertake specialist mental health training; (2) lawyers share the field with the trained members of other less-expensive non-lawyer schemes who provide a competent representational service; and (3) governments, law schools, and community sector organisations work collaboratively to develop cost effective schemes that use law students and other lay volunteers.

4.1 Ensuring effective mental health representation

The adversarialism approach of lawyers is not an insurmountable problem but one that can be overcome through education and training. An example is the English Mental Health Accreditation Scheme (MHAS) which covers the representation of people in all proceedings before the First-tier Tribunal (Mental Health) under the *Mental Health Act* 1983 (UK). In England, any lawyer who wishes to represent a client before the tribunal must be a member of the scheme. To become a member, the lawyer must attend, within the six months prior to applying for membership, a compulsory two day training course provided by a specifically approved training organisation. Membership is for three years and during this time the lawyer is required to demonstrate their continued suitability to remain in the scheme by successfully completing a process of re-accreditation. They must show that within the 12 month period preceding their reapplication that they represented at, or observed, four particularly defined, different types of tribunal hearings. They must also provide four written case reports between 750 and 1,000 words to demonstrate that they have both an understanding of the law and procedure, and an ability to represent clients effectively in tribunal proceedings.¹⁹⁵

MHAS members are required to demonstrate the following standards:

- Knowledge of the law and procedure which are essential to representing clients before First-tier Tribunal (Mental Health);
- Ability to prepare and present cases effectively for clients in proceedings before First-tier Tribunal (Mental Health);
- Sufficient knowledge of those areas of law, such as mental capacity, community care and human rights, which are relevant to advising and representing clients within the scope of the mental health franchise;

¹⁹⁵ The Law Society, *Mental Health* (January 2013) Accreditation Scheme Guidance <<http://www.lawsociety.org.uk/accreditation/specialist-schemes/mental-health/>>.

- Sensitivity to and awareness of the particular difficulties clients may face because of mental disorder and by virtue of being subject to Mental Health Act powers.
- Commitment to representing clients with mental disorder;
- Adherence to the terms and conditions of Law Society Accreditation Scheme Membership;
- Adherence to the Mental Health Accreditation Scheme code of practice.¹⁹⁶

Lawyers must also complete six hours of mental health law-related continuing professional development training each year and are required to show, to the satisfaction of the Law Society, that they have, and will maintain a high level of knowledge, skills, experience and practice in the area of mental health law.¹⁹⁷ If similar schemes were implemented in the different Australian states it would help ensure that lawyers worked more effectively within the non-adversarial, therapeutic legal framework of mental health tribunals.

6. MHTRS - QUEENSLAND STYLE

Carney, in his 2008 article, reported that Queensland Legal Aid rarely appeared before the Mental Health Review Tribunal.¹⁹⁸ The Tribunal reported that in that 2007/08 year, only 1.3% of people had appeared before the Tribunal represented.¹⁹⁹ Three years later, this figure had increased to 1.8%.²⁰⁰ In August 2012, the Queensland Public Interest Clearing House (QPILCH) commenced a program using volunteer law students to provide support and advocacy for patients on involuntary treatment orders who were required to appear before the tribunal. These volunteers are drawn from QPILCH's already existing large volunteer base and also from Queensland's universities such as the University of Queensland Pro Bono Centre. Philanthropic funding for the scheme has been secured until 2015.

¹⁹⁶ Ibid.

¹⁹⁷ Ibid.

¹⁹⁸ Terry Carney *et al.*, above n 2, 130.

¹⁹⁹ Mental Health Review Tribunal Queensland, Annual Report 2007/08, <http://www.health.qld.gov.au/mentalhealth/docs/annualreport_0708.pdf>.

²⁰⁰ Mental Health Review Tribunal Queensland, Annual Report 2010/11, <http://www.mhrt.qld.gov.au/wp-content/uploads/2012/06/mhrt-annual_report_2010-11.pdf>.

When the Coordinator of the scheme, Ann Herriot, was asked why she and her colleagues at QPILCH believed that a representation scheme needed to be developed and implemented, she replied:

Through our student mental health law clinic, we became aware of the appalling rate of assistance and representation of patients in the MHRT in Queensland (less than 2% which is the lowest rate in the country).²⁰¹

The Queensland scheme was patterned on the Tasmanian MHTRS which provided ongoing support and resources during the development process. Ann Herriot travelled to Tasmania and undertook the training course. When asked why QPILCH believed that the MHTRS was a suitable model to fill the representational void that had become so apparent in Queensland, she responded that:

We became aware of the Tasmanian model and given our relationship with University of Queensland (through the Mental Health Law Clinic) and the high numbers of competent, enthusiastic student volunteers already at QPILCH, we thought we could use this valuable resource to assist in addressing this issue. (QPILCH runs 6 student clinics in partnership with 4 universities and also has approximately 50 volunteers each year as well as PLT students). Our experience with students gave us confidence that students could provide competent non-adversarial assistance and this was confirmed by our research into the Tasmanian scheme. Personally, I also wanted to expose students, prior to embarking on their careers, to social justice issues to which they may not otherwise be exposed as a way of "inoculating" them - and hopefully encouraging a lifelong commitment to social justice issues.²⁰²

When asked to identify the reasons why some groups have been supportive of the process and other groups have not, Ms Herriot replied:

We have had tremendous support from students, University of Queensland, the Tribunal, hospital staff though we have not yet had access to a group of doctors at the hospital so we don't yet know whether they will be supportive of the scheme. There has been some anxiety from some lawyers. My impression is that this stems from the belief that only lawyers should be doing advocacy. This may be a lack of confidence in students or it may be territorial. It also

²⁰¹ Email from Ann Herriot, Coordinator, Student Programs, Queensland Public Interest Law Clearing House to author, 10 September 2012.

²⁰² Ibid.

could stem from the essentially adversarial/rights based approach of lawyers and a misunderstanding of therapeutic jurisprudence and the role of lay advocates.²⁰³

Although it is still very early days in Queensland's implementation of the scheme, the Coordinator was asked whether there was, as yet, any qualitatively identified advantages, or disadvantages for patients, tribunal, government, families, students, lawyers, and community from the scheme's implementation in Queensland. Her reply was:

We did our first official hearing a couple of weeks ago and the patient reported that it was the first time she felt that the Tribunal listened to her. The Tribunal adjourned the hearing because they were not convinced that the treating team had adequately considered the treatment criteria. This was a great outcome for the patient.²⁰⁴

While Queensland has implemented the MHTRS model, organisations in other states have begun lobbying for similar schemes in their jurisdictions. In the Australian Capital Territory, the Women's Centre for Health Matters Inc. Report 2010, *'Out of Reach: Women living with mental health issues in the ACT: What hinders their access to legal support?'* put forward the Tasmanian MHTRS as a model representation program that was 'sensitive to the needs of clients with mental health issues'²⁰⁵ The report referred to the lack of legal support and representation for people with mental health issues across Australia which was reported by the Mental Health Council of Australia in its 2005 report, *Not for Service*²⁰⁶ which stated that the MHTRS, 'in a short time, alleviated these deficiencies.'²⁰⁷

The Victorian Law Reform Commission released its Guardianship Consultation Paper 10²⁰⁸ in 2011 in which it presented an option that a model the same as the Tasmanian MHTRS could be created in which law students were engaged and trained to provide voluntary representation for people appearing before the

²⁰³ Ibid.

²⁰⁴ Ibid.

²⁰⁵ Kate Judd and Leigh Hale, 'Out of Reach: Women living with mental health issues in the ACT: What hinders their access to legal support?' (Research Report, Women's Centre for Health Matters, June 2010) 32.

²⁰⁶ Australian Human Rights Commission, 'Disability Rights: Not for Service - Experiences of Injustice and Despair in Mental Health Care in Australia' (Report, Mental Health Council of Australia, 19 October 2005).

²⁰⁷ Judd and Hale, above n 205, 31.

²⁰⁸ Victorian Law Reform Commission, 'Part 8 Implementing and Regulating New Laws' (Consultation Paper 10, VLRC, 2011) <http://www.lawreform.vic.gov.au/sites/default/files/Guardianship_CP_Part_8.pdf>.

Victorian Civil and Administrative Tribunal.²⁰⁹ In its Draft Mental Health (WA) Bill 2011 response submission to the Western Australian Parliament, the Aboriginal Legal Service Western Australia (ALSWA) also referred to the MHTRS, stating that ALSWA endorsed the Tasmanian approach and recommended ‘that efforts should be made to source and train Aboriginal and Torres Strait Islander law students, court officers or lawyers to be made available for any Aboriginal or Torres Strait Islander applicants who seek culturally or linguistically appropriate representation.’²¹⁰

There are different types of advocacy such as self advocacy, family and friend advocacy, peer advocacy, professional advocacy, statutory advocacy and legal advocacy, all of which may be linked, and all of which can help meet the needs and interests of a person during their lifetime situations. However, the person appearing in an administrative law forum at a time when authoritative decisions are being made that may deprive them of their fundamental rights and civil freedoms, is entitled to be represented by a legal, or other qualified representative²¹¹ who, if the client is unable to afford to appoint, must be paid by the state.²¹² As discussed previously, this is rarely the case in most Australian jurisdictions - evidence of the barriers to justice faced by people with a mental illness. It does raise the question, however, whether lawyers and law students who underwent specialist education and training similar to the education and training central to the MHTRS program would, in turn, become the more aware politicians, policy-makers, decision-makers and lawyers who could recognise the prejudice and unfairness associated with mental illness in the legal system, and promote plans for positive change.

6. CONCLUSION

A mental health hearing is a legal circumstance in which a compelled member of one of society’s most vulnerable groups is placed at risk of having fundamental

²⁰⁹ Ibid.

²¹⁰ Aboriginal Legal Service Of Western Australia (INC), Submission to the Western Australian Parliament, Draft Mental Health Bill (WA) 2011, March 2012, 16
<http://www.als.org.au/images/stories/publications/Submissions/ALSWA_Submission_on_Draft_Mental_Health_Bill_2011.pdf>.

²¹¹ United Nations, *Principles for the protection of persons with mental illness and for the improvement of mental health care*, Adopted by General Assembly Resolution 46/119 of 17 December 1991. Definitions - ‘Counsel’ means a legal or other qualified representative.

²¹² Ibid Principle 18.

freedoms taken away from them. It is a condition involving an imbalance of power where the powerful make life impacting decisions in a disempowered person's best interests. It is a complex issues forum where competing rights such as the person's rights to liberty and freedom from unnecessary intervention; to treatment, protection and care; and the right of the community to safety and protection are weighed and balanced. It is a judicial environment in which the right to qualified, effective representation is enshrined in law and yet, it is more often than not, a forum in which non-representation, or ineffective representation are the norms.

One purpose of Chapter Seven was to discuss the high costs associated with legal representation. From the perspective of both the potential client and the funding bodies, fiscal concern is a major barrier to the universal provision of legal representation before mental health tribunals and boards of review: an economic condition that is highly unlikely to improve in the coming years. The extremely low representational figures recorded in almost every Australian state and territory over the past decades have markedly improved when a structured lay volunteer representation strategy or program such as the Office of Official Visitors in Western Australia and the MHTRS in Tasmania has been implemented in the jurisdiction.

This chapter evaluated the Tasmanian Mental Health Tribunal Representation Scheme as a prospective solution for resolving the financial problems contributing to the problem of non-representation. The use of law student schemes has proven to be a cost effective option for governments and philanthropists, and one that academic commentators have suggested is a model that should be seriously considered as having the potential to rectify the unacceptable situation of non-representation. Australian organisations have lobbied to have schemes similar to the MHTRS implemented in their jurisdictions. In late 2012, the Queensland Public Interest Clearing House became the first organisation to implement its own program based on the Tasmanian MHTRS.

Research identifies law students as presenting an untapped, willing volunteer work force that, with training and supervision can provide effective representation in a number of poorly legally represented areas of law including child protection, anti-discrimination, and mental health and guardianship law. The evidence also suggests that a specially trained student is commonly a better representative than the

untrained legal practitioner who is usually adversarial in their practice and limited in their understanding and practical approach toward achieving therapeutic outcomes for their client.

A second intention of Chapter Seven was to show that through a program of specialist education, training and contact law students may achieve new and deeper understandings regarding the complexities of life for a person who is living with mental illness. They can grow in their awareness of the barriers that the person will encounter when they come face to face with the sanist legal system. By participating in clinical legal programs founded on principles of therapeutic jurisprudence that maximise appropriate mental health education and incorporated contact stratagems, students can learn skills and gain experience necessary to provide clients with mental illness with a legal service that holistically meets the needs of the client while zealously advocating their rights and interests.

The first six chapters of the thesis examined stigma and the prejudice and discrimination associated with mental illness. Chapters Seven followed on from the anti-stigma discussion in Chapters Three and Four. It reviewed the program elements that appear to have had the most success in positively changing the negative attitudes of university students. Importantly, for the purposes of this thesis, it presented the MHTRS as a program that fits within the parameters necessary to achieve successful attitudinal change. The following chapter quantitatively and qualitatively tests the proposition, and degree, of attitudinal negativity associated with mental illness that students have on entering law school, and again, on exiting law school. Can it be empirically supported that law students are sanist? Chapter eight tries to establish whether offering law students the opportunity to participate in programs similar to the MHTRS is likely to result in a long lasting, positive influence on their attitudes, which in future might contribute to ensuring greater access to effective representation; a reduction in stigma and prejudice in the legal system; and an increase in fairer outcomes for the vulnerable people who experience mental illness.

BIBLIOGRAPHY**A. Articles**

- Alexander, Laurel A and Bruce G Link, 'The impact of contact on stigmatizing attitudes toward people with mental illness' (2003) 12 *Journal of Mental Health* 271.
- Allan, Alfred, 'The Past, Present and Future of Mental Health Law: A Therapeutic Jurisprudence Analysis' (2003) 20 *Law in Context* 24.
- Angermeyer, Matthias C and Herbert Matschinger, 'The effect of personal experience with mental illness on the attitude towards individuals suffering from mental disorders' (1996) 31 *Social Psychiatry and Psychiatric Epidemiology* 321.
- Angermeyer, Matthias C *et al.*, 'Biogenetic explanations and public acceptance of mental illness: systematic review of population studies' (2011) 199 *The British Journal of Psychiatry* 367.
- Ashbrook, Alexandra M, 'The Unauthorized Practice of Law in Immigration: Examining the Propriety of Non-Lawyer Representation' (1991) 5 *Georgetown Journal of Legal Ethics* 237.
- Baker, Gregory and Jennifer Zawid, 'The Birth of a Therapeutic Court's Externship Program: Hard Labor But Worth the Effort' (2005) 17 *St. Thomas Law Review* 711.
- Beaupert, Fleur, 'Mental health tribunal processes and advocacy arrangements: 'Little Wins' are No Small Feat' (2009) 16 *Psychiatry, Psychology and Law* 90.
- Blair, Irene V, Bernadette Park and Jonathan Bachelor, 'Understanding intergroup anxiety: Are some people more anxious than others?' (2003) 6 *Group Processes and Intergroup Relations* 151.
- Brooks, Susan L, 'Practicing (And Teaching) Therapeutic Jurisprudence: Importing Social Work Principles and Techniques into Clinical Legal Education' (2005) 17 *St. Thomas Law Review* 513.
- Callaghan, Patrick *et al.*, 'Attitudes toward mental illness: Testing the contact hypothesis among Chinese student nurses in Hong Kong' (1997) 26 *Journal of Advanced Nursing* 33.
- Carney, Terry and David Tait, 'Mental Health Tribunals - Rights, Protection, or Treatment? Lessons from the ARC Linkage Grant Study' (2011) 18 *Psychiatry, Psychology and Law* 137.
- Carney, Terry and Fleur Alleen Beaupert, 'Mental health tribunals: Rights drowning in un-"chartered" health waters' (2008) 13 *Australian Journal of Human Rights* 181.
- Carney, Terry *et al.*, 'Advocacy and Participation in Mental Health Cases: Realisable Rights or Pipe-Dreams?' (2008) 26 *Law in Context* 125.
- Carney, Terry *et al.*, 'Mental Health Tribunals: 'TJ' Implications of Weighing Fairness, Freedom, Protection and Treatment' (2007) 17, *Journal of Judicial Administration* 46.
- Chinsky, Jack M and Julian M Rappaport, 'Attitude change in college students and chronic patients: A dual perspective' (1970) 35 *Journal of Consulting and Clinical Psychology* 388.

Clement, Sarah *et al.*, 'Filmed v. live social contact interventions to reduce stigma: randomised controlled trial' (2012) 201 *British Journal of Psychiatry* 57.

Cohen, Harry, 'Confronting Myth in the American Legal Profession: A Territorial Perspective' (1970) 22 *Alabama Law Review* 513.

Corrigan, Patrick W *et al.*, 'Challenging the Public Stigma of Mental Illness: A Meta-Analysis of Outcome Studies' (2012) 63 *Psychiatric Services* 963.

Corrigan, Patrick W *et al.*, 'Three strategies for changing attributions about severe mental illness' (2001) 27 *Schizophrenia Bulletin* 187.

Corrigan, Patrick W and Amy C. Watson, 'Understanding the impact of stigma on people with mental illness' (2002) 1 *World Psychiatry* 16.

Corrigan, Patrick W and Jenessa R Shapiro, 'Measuring the impact of programs that challenge the public stigma of mental illness' (2010) 30 *Clinical Psychology Review* 907.

Corrigan, Patrick W *et al.*, 'Mental illness stigma: problem of public health or social justice?' (2005) 50 *Social Work* 363.

Corrigan, Patrick W, 'How stigma interferes with mental health care' (2004) 59 *American Psychologist* 614.

Daicoff, Susan, 'Lawyer, Know Thyself: A Review of Empirical Research on Attorney Attributes Bearing on Professionalism' (1997) 46 *American University Law Review* 1337.

Dolan, Mairead, Robert Gibb and Placid Coorey, 'Mental health review tribunals: A survey of special hospital patients' opinions' (1999) 10 *Journal of Forensic Psychiatry* 264.

Duquette, Donald N and Sarah H Ramsey, 'Representation of Children in Child Abuse and Neglect Cases: An Empirical Look at what Constitutes Effective Representation' (1987) 20 *University of Michigan Journal of Law Reform* 341.

Fleming, Don and Anne Daly, 'The retreat of the legal profession from legal aid: labour market change in the Australian mixed model' (2007) 14 *International Journal of the Legal Profession* 21.

Freckelton, Ian, 'Mental Health Review Tribunal Decision-Making: A Therapeutic Jurisprudence Lens' (2003) 10 *Psychiatry, Psychology and Law* 49.

Freckelton, Ian, 'Therapeutic Jurisprudence Misunderstood and Misrepresented: The Price and Risks of Influence' (2008) 30 *Thomas Jefferson Law Review* 575.

Freiberg, Arie, 'Therapeutic Jurisprudence in Australia: Paradigm Shift or Pragmatic Incrementalism?' (2003) 20 *Law In Context* 6.

Geoffrey Wolff *et al.*, 'Community Knowledge of Mental Illness and Reaction to Mentally Ill People' (1996) 168 *The British Journal of Psychiatry* 191.

Haskell, Paul G, 'Teaching Moral Analysis in Law School' (1991) 66 *Notre Dame Law Review* 1025.

Hayes, Robert *et al.*, 'Stigma directed toward chronic illness is resistant to change through education and exposure' (2002) 90 *Psychology Reporter* 1161.

Hochberg, Jules D, 'The companion program: Implementing the manpower recommendations of the joint commission on mental illness and health' (1963) 18 *American Psychologist* 224.

Holmes, Paul E *et al.*, 'Changing attitudes about schizophrenia' (1999) 25 *Schizophrenia Bulletin* 447.

King, Michael S, 'Therapeutic Jurisprudence in Australia: New Directions in Courts, Legal Practice, Research and Legal Education' (2006) 15 *Journal of Judicial Administration* 129.

King, Michael S, 'Therapeutic Jurisprudence's Challenge to the Judiciary' (2011) 1 *Alaska Journal of Dispute Resolution* 1 <SSRN: <http://ssrn.com/abstract=2100632>>.

Kish, George B and Rosa-Weller Hood, 'Voluntary activity promotes more realistic conceptions of the mentally ill by college students' (1974) 2 *Journal of Community Psychology* 30.

Kolodziej, Monika E and Blair T Johnson, 'Interpersonal Contact and Acceptance of Persons With Psychiatric Disorders: A Research Synthesis' (1996) 64 *Journal of Consulting and Clinical Psychology* 1387.

Koschate, Miriam and Rolf van Dick, 'A multilevel test of Allport's contact conditions' (2011) 14 *Group Processes & Intergroup Relations* 769.

Kress, Ken, 'Therapeutic Jurisprudence and the Resolution of Value Conflicts: What We Can Realistically Expect, in Practice, from Theory' (1999) 17 *Behavioral Sciences and the Law* 555.

Link, Bruce G and Francis T. Cullen, 'Contact with the mentally ill and perceptions of how dangerous they are' (1986) 27 *Journal of Health and Social Behavior* 289.

Lyons, Michael and Jenny Ziviani, 'Stereotypes, Stigma, and Mental Illness: Learning From Fieldwork Experiences' (1995) 49 *The American Journal of Occupational Therapy* 1002.

Lyons, Mike and Robyn Hayes, 'Student Perceptions of Persons with Psychiatric and Other Disorders' (1993) 47 *The American Journal of Occupational Therapy* 541.

Mann, Caroline E and Melissa J Himelein, 'Putting the person back into psychopathology: An intervention to reduce mental illness stigma in the classroom' (2008) 43 *Social Psychiatry and Psychiatric Epidemiology* 545.

Moon, Sangjun *et al.*, 'Factors affecting social distance toward mental illness: a nationwide telephone survey in Korea' (2000) 41 *Preventive Medicine & Public Health* 419.

Morrison, James K *et al.*, 'An attempt to change the negative, stigmatizing image of mental patients through brief re-education' (1980) 47 *Psychological Reports* 334.

Neil Penny, Jack Kasar and Tony Sinay, 'Student attitudes toward persons with mental illness: The influence of course work and level II fieldwork' (2000) 55 *The American Journal of Occupational Therapy* 217.

Nolan-Haley, Jacqueline M, 'Lawyers, Non-Lawyers and Mediation: Rethinking The Professional Monopoly From A Problem-Solving Perspective' (2002) 7 *Harvard Negotiation Law Review* 235.

O'Brien, Molly Townes, 'Facing down the Gladiators: Addressing Law School's Hidden Adversarial Curriculum' (2011) 37 *Monash University Law Review* 43.

Paolini, Stefania *et al.*, 'Effects of direct and indirect cross-group friendships on judgments of Catholics and Protestants in Northern Ireland: The mediating role of an anxiety-reductive mechanism' (2004) 30 *Personality and Social Psychology Bulletin* 770.

Penn, David L *et al.*, 'Dispelling the stigma of schizophrenia: what sort of information is best?' (1994) 20 *Schizophrenia Bulletin* 567.

Perlin, Michael L 'A Law of Healing' (1999-2000) 68 *University of Cincinnati Law Review* 407.

Perlin, Michael L, 'They Keep It All Hid: The Ghettoization of Mental Disability Law and Its Implications for Legal Education' (2010) 54 *St. Louis University Law Journal* 857.

Pettigrew, Thomas F and Linda R Tropp, 'A meta-analytic test of intergroup contact theory' (2006) 90 *Journal of Personality and Social Psychology* 751.

Pettigrew, Thomas F and Linda R Tropp, 'How does intergroup contact reduce prejudice? Meta-analytic tests of three mediators?' (2008) 38 *European Journal of Social Psychology* 922.

Pettigrew, Thomas F, 'Secondary transfer effect of contact: Do intergroup contact effects spread to noncontacted outgroups?' (2009) 40 *Social Psychology* 55.

Pinfold, Vanessa *et al.*, 'Active ingredients in anti-stigma programmes in mental health' (2005) 17 *International Review of Psychiatry* 123.

Pinfold, Vanessa *et al.*, 'Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools' (2003) 182 *The British Journal of Psychiatry* 342.

Reinke, Rebecca R *et al.*, 'Examining two aspects of contact on the stigma of mental illness' (2004) 23 *Journal of Social and Clinical Psychology* 377.

Rottman, David B, 'Does Effective Therapeutic Jurisprudence Require Specialized Courts (and Do Specialized Courts Imply Specialist Judges)?' (2000) *Court Review* 26.

Rousseau, Annie and Anton F De Man, 'Authoritarian and socially restrictive attitudes toward mental patients in mental health volunteers and nonvolunteers' (1998) 83 *Psychological Reports* 803.

Scheibe, Karl E, 'College students spend eight weeks in mental hospital: A case report' (1965) 2 *Psychotherapy: Theory, Research and Practice* 117.

Schwartz, Chaya and Rinat Armony-Siva, 'Students' Attitudes to the Inclusion of People with Disabilities in the Community' (2001) 16 *Disability & Society* 403.

Shimmin, Carolyn, 'Understanding stigma through a gender lens' (2009) 11 *Canadian Women's Health Network* 14.

Silver, Marjorie A, 'Supporting Attorney's Personal Skills' (2009) 1 *Restiva Juridica Upr* 147.

- Slobogin, Christopher, 'Therapeutic Jurisprudence: Five Dilemmas to Ponder' (1995) 1 *Psychology, Public Policy & Law* 193.
- Stern, R.S., 'The cost of Mental Health Review Tribunals (1994) *Psychiatric Bulletin* 18, 578. <<http://pb.rcpsych.org/content/18/9/578.1.full.pdf>>.
- Stobbs, Nigel and Geraldine Mackenzie, 'Evaluating the Performance of Indigenous Sentencing Courts' (2009) 13 *Australian. Indigenous Law Review* 90.
- Stuart, Heather, 'Fighting the stigma caused by mental disorders: past perspectives, present activities, and future directions' (2008) 7 *World Psychiatry* 185.
- Tait, David, 'The Ritual Environment of the Mental Health Tribunal Hearings: Inquiries and reflections' (2003) 10 *Psychiatry, Psychology and the Law* 91.
- Thornicroft, Graham, 'Reducing stigma and discrimination: Candidate interventions' (2008) 2 *International Journal of Mental Health Systems* 1.
- Toki, Valmaine, 'Will Therapeutic Jurisprudence Provide a Path Forward for Maori' (2005) 13 *Waikato Law Review* 169.
- Vittoria, Anne K, 'The Elderly Guardianship Hearing: A socio-legal encounter' (1992) 6 *Journal of Aging Studies* 165.
- Wallach, Helene S, 'Changes in attitudes toward mental illness following exposure' (2004) 40 *Community Mental Health Journal* 235, 247.
- Walsh, Tamara and Heather Douglas, 'Lawyers, Advocacy And Child Protection' (2011) 35 *Melbourne University Law Review* 621.
- Weller, Penelope, 'Taking a Reflexive Turn: Non-Adversarial Justice and Mental Health Review Tribunals' (2011) 37 *Monash University Law Review* 81.
- Wexler, David B 'Therapeutic Jurisprudence in a Comparative Law Context' (1997) 15 *Behaviour Science and Law* 233.
- Williams, Valerie, 'The Challenge for Australian Jurisdictions to Guarantee Free Qualified Representation Before Mental Health Tribunals and Boards of Review: Learning from the Tasmanian Experience' (2009) 16 *Psychiatry, Psychology and Law* 108.
- Winick, Bruce J and David B Wexler 'The Use of Therapeutic Jurisprudence in Law School Clinical Education: Transforming the Criminal Law Clinic' (2006) 13 *Clinical Law Review* 605.
- Winick, Bruce J, 'Therapeutic Jurisprudence and the Civil Commitment Hearing' (1999) 10 *Journal of Contemporary Legal Issues* 37.
- Wright, Beatrice A, 'Developing constructive views of life with a disability' (1980) 41 *Rehabilitation Literature* 274.

B. Books

- Allport, Gordon W, *The Nature of Prejudice* (Addison-Wesley, Oxford, 1954).
- Jones, Edward E *et al.*, *Social Stigma: The Psychology of Marked Relationships* (W.H. Freeman, 1984).

Wexler, David B and Bruce J Winick (eds) *Law in a Therapeutic Key: Developments in Therapeutic Jurisprudence* (Durham, NC: Carolina Academic Press, 1996) John Petrla, 'Paternalism and the Unrealized Promise of Essays in Therapeutic Jurisprudence'.

C. Grey Literature -Research Papers, Reports, Submissions, Letters, Memos etc

Aboriginal Legal Service of Western Australia (INC) Submission to the Western Australian Parliament, *Draft Mental Health Bill WA 2011* (Submission, Aboriginal Legal Service of Western Australia , March 2012)
<http://www.als.org.au/images/stories/publications/Submissions/ALSWA_Submission_on_Draft_Mental_Health_Bill_2011.pdf>.

Advocacy Tasmania Inc., 'Inquiry into Legal Aid and Access to Justice' (Submission, Advocacy Tasmania Inc., September 2003)
<http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Committees?url=legcon_ctte/completed_inquiries/2002-04/legalaidjustice/submissions/sub39.doc>.

Australian Council of Social Service, 'Are you being served: indicators for capacity building of community sector services' (Research Paper, Australian Council of Social Service, 2005).

Australian Council of Social Services, 'Australian Community Sector Survey: 2007 National Report' (Report, Australian Council of Social Service, February 2007).

Australian Human Rights Commission, 'Disability Rights: Not for Service - Experiences of Injustice and Despair in Mental Health Care in Australia' (Report, Mental Health Council of Australia, 19 October 2005).

Cameron, Prue and Jo Flanagan, 'Thin Ice: Living With Serious Mental Illness and Poverty in Tasmania' (Report, Social Action and Research Centre, Anglicare Tasmania, May 2004).

Collins English Dictionary, online
<<http://www.collinsdictionary.com/dictionary/english/qualified>>

Colvin, Debora , Head of the Council of Official Visitors (Telephone Interview 20 February 2013).

Council of Social Services New South Wales, 'Government's short sighted cost-cutting trumps rehabilitation of young offenders' (Media Release, 5 July 2012)
<<http://www.ncoss.org.au/content/view/6907/98/>>.

Denniss, Richard, Josh Fear and Emily Millane, 'Justice for all: Giving Australians greater access to the legal system' (Institute Paper No 8, The Australian Institute, 8 March 2012)
<<http://www.tai.org.au/node/1831>>

Draft Mental Health Bill 16 December 2011, Mental Health Law Centre (WA) Inc. Submission Legal Representation At Mental Health Tribunal Hearings, 14.

Elferink, John, Northern Territory Attorney-General and Minister For Justice, 'Focus on Providing Core Services' (2012 -13 Mini Budget Media Release, 4 December 2012)
<<http://newsroom.nt.gov.au/index.cfm?fuseaction=printRelease&ID=10130>>.

Email from Ann Herriot, Coordinator, Student Programs, Queensland Public Interest Law Clearing House to author, 10 September 2012.

Gleeson, Murray, Current Issues For The Australian Judiciary, Speech to Supreme Court of Japan, Tokyo - 17 January 2000,
<http://www.hcourt.gov.au/assets/publications/speeches/former-justices/gleesoncj/cj_Japanj.htm>.

Judd, Kate and Leigh Hale, 'Out of Reach: Women living with mental health issues in the ACT: What hinders their access to legal support?' (Research Report, Women's Centre for Health Matters, June 2010) 32.

Justice Peggy Fulton Hora, 'Therapeutic What?' (2006)
<http://www.judgehora.com/therapeutic_what.pdf>.

Karras, Maria *et al.*, 'On The Edge Of Justice: Access To Justice And Legal Needs' (Report, Volume 4, Law And Justice Foundation Of New South Wales, May 2006)
<[http://www.lawfoundation.net.au/ljf/site/articleIDs/CB05FD97AAF2458CCA25718E00014293/\\$file/EdgeOfJustice.pdf](http://www.lawfoundation.net.au/ljf/site/articleIDs/CB05FD97AAF2458CCA25718E00014293/$file/EdgeOfJustice.pdf)>.

King, Michael S, 'Solution-Focused Judging Bench Book' (Bench Book, Australasian Institute of Judicial Administration Incorporated, 2009)
<<http://www.aija.org.au/Solution%20Focused%20BB/SFJ%20BB.pdf>>.

Law Council of Australia and the Australian Institute of Judicial Administration National Legal Aid, 'Erosion of Legal Representation in the Australian Justice System' (Report, Law Council of Australian and the Australian Institute of Judicial Administration National Legal Aid, February 2004) <<http://www1.lawcouncil.asn.au/lawcouncil/images/LCA-PDF/a-z-docs/fmsdownload079a.pdf>>.

Legal Aid Commission of New South Wales, 'Review of the NSW Community Legal Centres Funding Program' (Final Report, Legal Aid Commission of NSW, February 2006).

McLeod, Rosie *et al.*, 'Court experience of adults with mental health conditions, learning disabilities and limited mental capacity' (Report No 2, Ministry of Justice Research Series, 9 – 10 July 2010).

Mental Health Review Board of Victoria, 'Annual Report for the year ending 30 June 2003' (Report, Mental Health Review Board of Victoria, 13 October 2003)
<<http://www.mhrb.vic.gov.au/images/stories/mhrb/publications/annualreports/ar2003.pdf>>.

Mental Health Review Board Western Australia, 'Annual Report 2003' (Report, Mental Health Review Board Western Australian, 2003)
<http://www.mhrbwa.org.au/publications/pdfs/Annual_Report_2003.pdf>.

Mental Health Review Tribunal New South Wales, 'Annual Report 2011/12' (Report, Mental Health Review Tribunal NSW, 2011/12)
<<http://www.mhrt.nsw.gov.au/assets/files/mhrt/pdf/Annualreportfinal2012.pdf>>

Mental Health Review Tribunal of NSW (Annual Report, Mental Health Review Tribunal of NSW, 2011/2012) <<http://www.mhrt.nsw.gov.au/mhrt/pdf/Annualreportfinal2012.pdf>>.

Mental Health Review Tribunal Queensland, 'Annual Report 2007/08, (Report, Mental Health Review Tribunal Queensland, 2007/08) <
http://www.health.qld.gov.au/mentalhealth/docs/annualreport_0708.pdf>.

Mental Health Review Tribunal Queensland, 'Annual Report 2010/11' (Report, Mental Health Review Tribunal Queensland, 2010/11) < http://www.mhrt.qld.gov.au/wp-content/uploads/2012/06/mhrt-annual_report_2010-11.pdf>.

Mental Health Tribunal Tasmania, 'Annual Report 2011 – 12' (Report, Mental Health Tribunal Tasmania 2011/2012)

<http://www.mentalhealthtribunal.tas.gov.au/__data/assets/pdf_file/0008/226493/Website_Copy_-_MHT_2011-12_.pdf>.

Office of the Official Visitors Western Australia, Annual Report 2009/10' (Report, Office of the Official Visitors Western Australia, 2009/10)

Office of the Official Visitors, Western Australia, 'Annual Report 2011/12' (Report, Office of the Official Visitors Western Australia, 2011/12)

<http://www.mhrbwa.org.au/publications/pdfs/Annual_Report_2012.pdf>

Queensland Council of Social Services, 'QCOSS Commentary State Budget 2012-13' (Commentary, Queensland Council of Social Services 2013) <

https://www.qcoss.org.au/sites/default/files/QCOSS_Budget_Commentary_2012-13.pdf>.

Rabkin, Judith G, Lenore Gelb and Joyce B Lazar (eds) *Attitudes Toward the Mentally Ill: Research Perspectives*, Judith G Rabkin, Determinants of Public Attitudes About Mental Illness: Summary of the Research Literature, (U.S. Department of Health and Human Services, 1980).

Rigby, Debra, 'Tasmanian Health Representation Project – A Practical Example of Therapeutic Jurisprudence' (Paper presented at 3rd International Conference on Therapeutic Jurisprudence, Perth Western Australia, 7-9 June 2006).

Senate Legal and Constitutional Affairs Reference Committee, *Access to Justice*, December 2009.

Sharman, Diane, MHTRS Coordinator, (Face to face interview, Hobart, June, 2012).

The Law Society, *Mental Health* (January 2013) Accreditation Scheme Guidance

<<http://www.lawsociety.org.uk/accreditation/specialist-schemes/mental-health/>>.

The Mental Health Review Tribunal, New South Wales Government, *The Tribunal* (21 February 2013) <<http://www.mhrt.nsw.gov.au/>>.

Victorian Law Reform Commission, 'Part 8 Implementing and Regulating New Laws' (Consultation Paper 10, VLRC, 2011)

<http://www.lawreform.vic.gov.au/sites/default/files/Guardianship_CP_Part_8.pdf>.

D. International law instruments

United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care

E. Legislation and Regulations

Civil and Administrative Tribunal Act 2008 (ACT).

Mental Health (Treatment and Care) Act 1994 (ACT).

Mental Health Act 1986 (Vic).

Mental Health Act 1993 (SA).

Mental Health Act 1996 (Tas).

Mental Health Act 2013 (Tas).

Mental Health Act 1996 (WA)

Mental Health Act 2000 (NSW).

Mental Health Act 2000 (Qld).

Mental Health Act 2009 (SA)

Mental Health and Related Services Act 2009 (NT).

Mental Health Bill 2012 (Tas).

F. Cases

Gideon v Wainwright (1963) 372 US 335.

Li Shi Ping v Minister for Immigration, Local Government and Ethnic Affairs (1994) 35 ALD 557.

LM v Latvia [2011] ECHR, Application No 26000/02, 19 July 2011

G. Media and websites

‘Cosmetic anti-stigma campaigns miss the point’ (2012) 4 *North Shore Schizophrenia Advocacy Bulletin* <<http://www.northshoreschizophrenia.org/images/2012%20Feb%20Advocacy%20Bulletin.pdf>>.

Andrews, Louis, ‘Legal Aid calls for funding increase’, *The Canberra Times* (online), 5 October 2012 <<http://www.canberratimes.com.au/act-news/legal-aid-calls-for-funding-increase-20121004-272n0.html>>.

Christean, Arthur G, ‘Therapeutic Jurisprudence: Embracing a Tainted Ideal’ (2002) *Focus On Utah* <<http://psychrights.org/articles/TherapeuticJurisprudenceTaintedIdeal.htm>>.

de Krester, Hugh, ‘Frontline aid needs funding lifeline’, *The Australian* (online), 1 February 2013 <<http://www.theaustralian.com.au/business/legal-affairs/frontline-aid-needs-funding-lifeline/story-e6frg97x-1226566254383>>.

Editorial, ‘Quiet death of the youth drug court’, *The Sydney Morning Herald*, 9 July 2012 <<http://www.smh.com.au/opinion/editorial/quiet-death-of-the-youth-drug-court-20120708-21p7h.html>>.

Hadfield, Gillian, ‘Lawyers, make room for nonlawyers’ *CNN* (online) 25 November 2012 <http://edition.cnn.com/2012/11/23/opinion/hadfield-legal-profession/index.html?utm_source=twitterfeed&utm_medium=linkedin&utm_campaign=Feed%3A+rss%2Fcnn_latest+%28RSS%3A+Most+Recent%29&goback=.gde_123735_member_190285594>.

Horin, Adele, ‘Youth drug court victim of budget cuts, say Salvos’, *The Sydney Morning Herald* (online), 11 July 2012 <<http://www.smh.com.au/national/youth-drug-court-victim-of-budget-cuts-say-salvos-20120710-21ty6.html>>.

Metherell, Mark, ‘Mental health failure tied to prejudice: McGorry’, *The Age* (online), 23 June 2010 <<http://www.theage.com.au/national/mental-health-failure-tied-to-prejudice-mcgorry-20100622-yvuf.html>>.

CHAPTER EIGHT

EMPIRICAL FINDINGS OF LAW STUDENT ATTITUDES TO PEOPLE WHO EXPERIENCE MENTAL ILLNESS

1. INTRODUCTION

Perlin argues that sanism is far more troubling than any of the other, more familiar, ‘isms’ such as racism and sexism because the prejudices associated with mental illness shape what is, a widely practiced, and socially acceptable, type of bigotry.¹ And, rather than being immune to this bigotry, the legal system propagates it. He suggests that it is the legal system’s acceptance of sanist myths that are constructed from stereotypes, typification and deindividualisation, which leads inevitably to the implicit and explicit questioning of the competence, capability and credibility of a legal party who has experienced mental illness, and the trivialisation of their legal problems.² The importance of sanist theory is its potential to expose the stigmatised and prejudicial attitudes of the law’s actors and the entrenched discriminatory practices, which Perlin contends pervades the legal system, largely unnoticed and unquestioned. However, Perlin does concede that his understanding of sanism developed from his personal observations and that it lacks a scientific basis.³

This chapter presents the results of an empirical study undertaken for the purpose of testing aspects of Perlin’s observations and assertions. As is explained at Section 2.0, below, studies have researched law student prejudices generally, but when a study has focused on mental illness prejudice expressly, its locus has tended to be the impact that stigma has on law students’ failure to seek help and treatment. To the best of this author’s knowledge, the present study is the first to compare the attitudes of law students on their entry into law school with the attitudes of students on their exit from legal education. The study examines the influences that social dominance orientation, liberalism, curriculum, gender and age have on the students’

¹ Michael L Perlin, ‘You Have Discussed Lepers and Crooks: Sanism in Clinical Teaching’ (2003) 9 *Clinical Law Review* 683.

² Ibid.

³ Ibid.

reported attitudes toward people who experience mental illness, generally, and legal clients who experience mental illness, specifically. Assessing and understanding the attitudes of law students is the incipience of positive systemic change.

This chapter builds on the discussion contained in the preceding chapter in an important way. Chapter Seven discussed the Mental Health Tribunal Representation Scheme (MHTRS). It suggested that the MHTRS might positively alter student attitudes, thereby reducing sanism in the legal system. This was argued on that basis that the MHTRS was built on principles of therapeutic jurisprudence; that it delivered a short, appropriate mental health education program that was developed particularly for law students; and that it provided student participants with the opportunity for professional face to face contact between themselves and their mental health clients. As discussed in Chapter Four, research has shown that participation in short structured mental health courses can have a small, but positive impact on the attitudes⁴ of young people⁵ and that attitudes are more improved if the program includes personal contact between the students and people who experience mental illness.⁶ The second contribution of Chapter Eight is its examination of the influence that participation in the MHTRS has on its participants. It questions whether MHTRS participant respondents express more positive, less sanist sentiments compared to non-participant respondents.

This chapter has seven main sections. The first, Section 2.0, notes previous research on student attitudes to mental illness. At Section 3.0, literature on the use of university students in attitudinal research is briefly outlined. Section 4.0 is the method section, which essentially follows a science structure. It explains the objectives of the study and details the development and procedures of the survey instrument. It discusses the methodological issues pertinent to Likert scales – notably explaining how the phenomena of social desirability and acquiescence bias can affect data. The results of the study are presented at Section 5.0, which responds to each of the core research questions, examines variables such as gender,

⁴ Patrick Corrigan, 'How Stigma Interferes With Mental Health Care' (2004) 59 *American Psychologist* 614.

⁵ Amy C Watson, 'Changing Middle Schoolers' Attitudes About Mental Illness Through Education' (2004) 30 *Schizophrenia Bulletin* 563. See also Petrus Ng and Kai-Fong Chan, 'Attitudes towards people with mental illness. Effects of a training program for secondary school students' (2002) 14 *International Journal of Adolescent Medical Health* 215.

⁶ Sosei Yamaguchi, Yoshio Mino and Shahir Uddin, 'Strategies and future attempts to reduce stigmatisation and increase awareness of mental health problems among young people: a narrative review of educational interventions', (2011) 65 *Psychiatry and clinical neurosciences* 405.

personal experience of having a mental illness and MHTRS participation, and presents Tables and Figures that show data outcomes. Section 6.0 discusses the influence that concepts such as ‘no opinion’ reporting and ‘social desirable’ reporting had on the analysis of reported responses when trying to determine the levels of authoritarianism and benevolence, and the use of stereotypes amongst students.

The conclusion at Section 7.0 reports that, in broad terms, the findings of the present study show that opinionated law students are sanist as they hold strongly benevolent and authoritarian prejudices. There were few discernible differences between the prejudices of the entry level 1st year law students and the exit level, final year law students. The 1st year group was more stereotypical in its attitudes. There were inconsistencies and insufficiencies in the data that prevented reaching a determination that participation in the Mental Health Tribunal Representation Scheme positively influences participant respondent’s attitudes. Important areas requiring further research are identified. This chapter supports the contention of this thesis that there is a need for politicians, judges, lawyers, legal academics and law students to work together to ensure that in future, the legal system provides people experiencing mental illness with access to a respectful, fair and equal, non-prejudiced and non-discriminatory, non-sanist playing field.

All statistical analyses presented in this chapter were undertaken by a research assistant, Dr Jason Little, in collaboration with the PhD candidate and her supervisors.

2. CURRENT ATTITUDES OF LAW STUDENTS TOWARD MENTAL ILLNESS

University student prejudice is a topic of enquiry that has generated a considerable body of social science research, which has consistently found that university students exhibit high levels of intolerance toward mental illness.⁷ Examining

⁷ Darcy Haag Granello and Paul F Granello, ‘Defining Mental Illness: The Relationship Between College Students’ Beliefs About the Definition of Mental Illness and Tolerance’ (2000) 3 *Journal of College Counseling* 100. See also Mike Lyons and Robyn Hayes, ‘Student Perceptions of Persons with Psychiatric and Other Disorders’ (1993) 47 *The American Journal of Occupational Therapy* 541. Also Ashum Gupta and Pushpa Bonnell, ‘Opinions about mental illness among college students’ (1993) 9 *Journal of Personality and Clinical Studies* 63.

prejudice broadly, Guimond undertook four separate studies using university students. Two of his studies used law students and psychology students while the other two selected participants randomly from educational disciplines. Guimond found that, as a consequence of social dominance orientation (SDO), law students were more prejudiced than students who were not studying for the 'power professions'.⁸

According to SDO theory, prejudice is simply a manifestation of a universal human tendency to form group based structures of social dominance in which the members of one group have the means and desire to subjugate the 'Others'.⁹ 'The mere fact of being in a dominant social position is sufficient to generate prejudice and ingroup bias'.¹⁰ Teachers, families and students perceive that within the hierarchical structure of academic disciplines, legal study has the higher prestige and status. This perception has an immediate impact on law students as they enter their first year of law school.¹¹ By comparing the levels of prejudice of the first year respondents against those of the final year respondents, Guimond concluded that because SDO is a generating mechanism, students become more prejudiced as they advance through to final year study.¹²

Despite recent efforts to reduce stigma on university campuses, relative mental illness bias, both implicit and explicit, continues to remain evident amongst students.¹³ This was the finding of the recent major Australian depression study, *Courting the Blues*, which presented a cross-sectional survey of 741 law students, 924 solicitors and 756 barristers.¹⁴ Students were recruited from 13 Australian universities. The study concluded that, generally, law students hold negative attitudes and stigmatising views regarding mental illness and that they have a low level of knowledge of mental health issues. It found that 22.8% of the respondents (more than one in five) thought that depressed people were dangerous to others; 7.4% believed that the person only had themselves to blame for their illness; and

⁸ Serge Guimond *et al.*, 'Does Social Dominance Generate Prejudice? Integrating Individual and Contextual Determinants of Intergroup Cognitions' (2003) 84 *Journal of Personality and Social Psychology* 697, 723.

⁹ Rupert Brown, *Prejudice: Its Social Psychology* (John Wiley & Sons, 2010).

¹⁰ Guimond, above n 8, 709.

¹¹ *Ibid.*

¹² *Ibid.*

¹³ Bethany A Teachman, Joel G Wilson and Irina Komarovskaya, 'Implicit and Explicit Stigma of Mental Illness in Diagnosed and Healthy Samples' (2006) 25 *Journal of Social and Clinical Psychology* 75.

¹⁴ Norm Kelk *et al.*, 'Courting the Blues: Attitudes towards depression in Australian law students and legal practitioners' (Report, Brain & Mind Research Institute, 2009)

36% thought that they were bad parents, a common contention that was discussed at length in Chapter Six.¹⁵

The study suggested that a reason for the students' display of negative attitudes could be because they belong to a cohort of clever and competitive perfectionists that have high expectations of themselves and others, and who are, generally, rather hard on themselves, and others.¹⁶ *Courting the Blues* demonstrates that Australian law students share the same mental illness prejudices as the rest of the community at levels that are statistically comparable, or higher, than indicated in the general public studies discussed in previous chapters.

3. UNIVERSITY STUDENT ATTITUDES USED IN RESEARCH

The use of university students as research subjects is widely practised. It is estimated that 90% of prejudice researchers rely on student samples.¹⁷ In 1986, Slade suggested that 75% of all published research in social psychology employed student participants.¹⁸ This had not altered when twenty years later, Arnett found that 67% of all American samples, and 80% of all samples from other countries, were comprised solely of psychology undergraduates.¹⁹ Given the required consents and practical, financial and ethical challenges that are associated with subject recruitment, it is understandable why researchers have become reliant on the minimum time and cost, convenience samples of university students. However, the saturated involvement of student participants from Western industrialised countries²⁰ has given cause for criticism, skepticism, and suggestions, which try to mitigate the barriers and increase the diversity of the samples.²¹ The issue of the external validity of generalisations from student samples applied to larger adult

¹⁵ Ibid Table 38a, 32.

¹⁶ Ibid iii.

¹⁷ P J Henry, 'College Sophomores in the Laboratory Redux: Influences of a Narrow Data Base on Social Psychology's View of the Nature of Prejudice' (2008) 19 *Psychological Inquiry: An International Journal for the Advancement of Psychological Theory* 49.

¹⁸ Michael E Gordon, L Allen Slade and Neal Schmitt, 'The "Science of the Sophomore" Revisited: from Conjecture to Empiricism' (1986) 11 *Academy of Management Review* 191.

¹⁹ Jeffrey Jensen Arnett, 'The neglected 95%: Why American psychology needs to become less American' (2008) 63 *American Psychologist* 7, 602.

²⁰ Joseph Henrich, Steven J. Heine and Ara Norenzayan, 'The weirdest people in the world?' (2010) 33 *Behavioral and Brain Sciences*, 61.

²¹ Nilanjana Dasgupta and Matthew Hunsinger, 'The Opposite of a Great Truth Is Also True: When Do Student Samples Help Versus Hurt the Scientific Study of Prejudice?' (2008) 19 *Psychological Inquiry* 90.

populations of interest has become a widely endorsed concern for critics²² who view student samples as a major hindrance to drawing inferences from experimental studies.²³

Emerging adulthood has been categorised as a period of the life course distinct to adulthood and consequently, unrepresentative of the adult public.²⁴ Bender suggests that the motivational and cognitive characteristics of student participants change from week to week.²⁵ Sears indicates that young adults change their attitudes more often, have less stable social and political views, have attitudes that are less likely crystallised, have a less-formulated sense of self, stronger cognitive skills and tendencies to comply with authority, and more unbalanced peer-group relationships.²⁶ Henry claims that because of the many known constructs and developmental differences related to prejudice, especially with respect to attitudes, identity, and the self that exist between students and non-students, the prejudice literature is likely to be vulnerable to generalisability problems.²⁷ He argues that ‘the university setting itself is an exceptional place where prejudice issues are made particularly salient and politicised within a liberal climate’²⁸ which may influence student responses in prejudice research as well as influence the ‘very questions and topics’²⁹ studied.

Generalisation is not, however, a major issue in this study. The primary purpose of the research is not to apply its findings to the wider public but to collect data regarding the attitudes of students at the time of entry into law school, and compare and analyse the data with data collected from students exiting law school. The characteristics and attributes of students used by critics to support the unrepresentativeness of the adult public argument, such as having less crystallised

²² Robert Rosenthal and Ralph L Rosnow, *Essentials of behavioral research: Methods and data analysis* (McGraw-Hill, 1991).

²³ James N Druckman and Cindy D Kim, ‘Students as Experimental Participants: A Defense of the “Narrow Data Base”’ in James N Druckman *et al.*, (eds), *Cambridge Handbook of Experimental Political Science*, (Cambridge University Press, 2011).

²⁴ Jeffrey Jensen Arnett, ‘Emerging adulthood: A theory of development from the late teens through the twenties’ (2000) 55 *American Psychologist* 469.

²⁵ Timothy A Bender, ‘Time of participation effect and grade-orientation’ (2007) 43 *Personality and Individual Differences* 1175.

²⁶ David O Sears, ‘College Sophomores in the Laboratory: Influences of a Narrow Data Base on Social Psychology’s View of Human Nature’ (1986) 51 *Journal of Personality and Social Psychology* 515.

²⁷ Henry, see above n 17. See also Arnett, above n 24 and Sears, above n 26.

²⁸ Henry, above n 17, 50.

²⁹ *Ibid.*

attitudes are the same characteristics and attributes which stamps the present research sample as a fertile field ready for sowing attitudinal change.

4. METHODS

This section describes essential features of the study; the development of the instrument; the procedures used to administer the survey; and the methodological issues raised.

4.1 Development of the instrument

The instrument used was a reformulation of the Emotional Reaction to Mental Illness Scale (ERMIS)³⁰ and the *Cohen and Struening's* Opinions about Mental Illness Scale (OMI).³¹ As discussed in Chapter Three, since the first studies were designed in the late 1940s, a substantial body of research has emerged rising from a need to know about public attitudes to mental illness. Along side this need, a parallel need to produce a reliable and valid instrument for measuring stigmatisation has developed.³² The OMI scale was one of the earliest of these instruments. It drew upon existing scales such as the Custodial Mental Illness Ideology Scale.³³ It comprised five Likert scales empirically derived from a five factor analysis of responses to 100³⁴ opinion statements.

The five OMI factors were authoritarianism, benevolence, mental hygiene ideology, social restrictiveness and interpersonal etiology. Factor analysis identified that the two factors that accounted for the greatest variance were authoritarianism and benevolence, both of which are considered to be prejudices rather than stereotypes as they are representative of the respondent's agreement with these attitudes.³⁵ It is

³⁰ Matthias C Angermeyer, Anita Holzinger and Herbert Matschinger, 'Emotional reactions to people with mental illness' (2010) 19 *Epidemiologia e Psichiatria Sociale* 26.

³¹ Jacob Cohen and E L Struening, 'Opinions about mental illness in the personnel of two large mental hospitals' (1962) 64 *Journal of Abnormal and Social Psychology* 349.

³² Glenn V Ramsey and Melita Seipp, 'Attitudes and opinions concerning mental illness' (1948) 22 *Psychiatric Quarterly* 428. See also Glenn V Ramsey and Melita Seipp, 'Public opinions and information concerning mental health' (1948) 4 *Journal of Clinical Psychology* 397.

³³ Doris C Gilbert and Daniel J Levinson, 'Ideology, Personality and Institutional Policy in the Mental Hospital' (1956) 53 *Journal of Abnormal Social Psychology* 263.

³⁴ The OMI was reduced in a later paper to 51 items.

³⁵ Patrick W Corrigan *et al.*, 'Prejudice, Social Distance, and Familiarity with Mental Illness' (2001) 27 *Schizophrenia Bulletin* 219, 220.

these two factors, authoritarianism and benevolence, that are used in this thesis' study.

1. authoritarianism, whereby obedience to authority is critical and people experiencing mental illness are considered different and inferior and require coercive handling;
2. benevolence, a moral point of view that represents sympathetic, kind, encouraging and paternalistic although fearful attitudes which are supported by humanistic and religious theories rather than scientific ones.

Social psychologists have, until recently, predominately focused their stigma research on stereotypes and degrees of social distance, to the extent that they had become “stereotypical” about stereotypes’.³⁶ The early belief was that if misleading and destructive stereotypes could be eliminated, inter-group harmony would be enhanced.³⁷ This centring of mental health research on the concept of stigma prejudice resulted in little being published on the emotional reactions people had to mental illness. Much of the available literature on emotional reaction comes from Angermeyer and Matschinger who developed the Emotional Reaction to Mental Illness Scale (ERMIS).³⁸ This tool is used to assess the extent that personal experience with mental illness influences attitudes.

Prejudice is not just negative thoughts but also includes ‘emotionally laden attitudes involving anxiety, anger, resentment, hostility, distaste or disgust’.³⁹ Angermeyer summated that there were three types of emotional reactions to people with mental illness - fear, pity, and anger. The public demonstrated so-called positive emotions (pity) most frequently, followed by fear then anger. It is questionable, however, whether pity can ever constitute a positive emotional reaction as it is an element of benevolence that stigmatises a person as helpless and childlike; someone to be tolerated and pitied by the normal person. Attitudes of benevolence are counterintuitive because while categorising people as helpless and childlike might lead to helping behaviours, it can also engender perceptions of irresponsibility and

³⁶ Vlad Glăveanu, ‘Stereotypes Revised – Theoretical Models, Taxonomy and the Role of Stereotypes’ (2007) 3 *Europe’s Journal of Psychology* (online) <<http://ejop.psychopen.eu/article/view/409/308>>.

³⁷ Ibid.

³⁸ Angermeyer, above n 30.

³⁹ Graham Thornicroft and Aliya Kassam, ‘Public attitudes, stigma and discrimination against people with mental illness’ in Craig Morgan, Kwame McKenzie and Paul Fearon (eds), *Society and Psychosis* (Cambridge University Press, 2008) 18.

uncontrollability, attributes that can reinforce the fear and anger that drives the establishment of restrictive processes and laws.⁴⁰ It was important for the present study to compare the responses of the students who identified as having had a mental illness with those who had not to identify any discernible differences.

4.1.1 Final page Q4 coding system

The instrument also included a final page of 8 additional questions (See Appendix 3). Question 4 was one of the most important questions on the survey because it gave little guidance or ‘clues’ to respondents as to what might be an appropriate response. It simply asked respondents to write down five words that best described their feelings about people who experience mental illness. So as to produce quantitative data from the qualitative responses, a coding system was developed by the researcher which was based on Cohen and Struening’s OMI scale⁴¹. It included four constructs of which, the first three (a) ‘benevolence’, (b) ‘authoritarianism, fear and avoidance’, and (c) ‘mental health literacy’ were derived from the OMI Scale. An additional category, (d) ‘other’ was included. The researcher individually coded all responses.

According to Cohen and Struening, the three most commonly held stereotypical misconceptions underpinning stigmatising attitudes are benevolence, authoritarianism and fear.⁴² The benevolent construct was taken to include all sentiments that expressed paternalism/maternalism - pity, incapability, dysfunction, vulnerability and restriction. Research shows that authoritarians report high levels of fear, and that the strongest association between authoritarianism and fear involves social differences of appearance or behaviour that deviate from the common social norms.⁴³ Avoidance is a correlation of authoritarianism⁴⁴ so it was decided to combine authoritarianism, fear and avoidance into the one construct. It

⁴⁰ Corrigan, above n 35, 223.

⁴¹ Cohen, above n 31.

⁴² Patrick W Corrigan and Amy C Watson, ‘Understanding the impact of stigma on people with mental illness’ (2002) 1 *World Psychiatry* 16. See also Patrick W Corrigan, Amy Kerr and Lissa Knudsen, ‘The stigma of mental illness: Explanatory models and methods for change’ (2005) 11 *Applied and Preventive Psychology*, 179. Also Paul E Holmes *et al.*, ‘Changing attitudes about schizophrenia’ (1999) 25 *Schizophrenia Bulletin* 447.

⁴³ Corey J Butler, ‘Authoritarianism and fear responses to pictures: The role of social differences’ (2013) 48 *International Journal of Psychology* 18.

⁴⁴ Corrigan, above n 35. See also Doyle P Johnson, ‘Religious Commitment, Social Distance, and Authoritarianism’ (1977) 18 *Review of Religious Research* 99.

included sentiments that expressed intolerance, social distance, legal restriction and compulsion and fear.

The third construct, ‘mental health literacy’ was derived from Cohen’s ‘mental hygiene ideology’ which had as its main tenet that ‘mental illness is an illness like any other’. It gave an indication of the level of awareness respondents had regarding mental illness, and the issues faced by people who experience mental illness. This construct included sentiments that expressed feelings of ignorance and the need for more scientific factual information. It also included sentiments that indicated the medical model ‘mental illness is an illness like any other’ approach. This was particularly important in the evaluation of the impact that participation in the MHTRS had on respondents as the variances between participants and non-participant groups could be analysed.

4.2 The use of the Likert scale

The survey format was a summated, multi-point Likert scale questionnaire design which, despite criticism from some commentators,⁴⁵ is generally considered to be an efficient method for gathering factual information and opinions from large numbers of respondents. The simplicity and versatility of the Likert scale⁴⁶ with its classic structure of a series of statements, or Likert Items, divided into two parts, stem statement and response, is ubiquitous in academic research. It is most particularly utilised when the value sought is one of opinion, belief or attitude⁴⁷ as was the aim of this study. Familiarity and ease of use also contributed to the researcher’s decision to use a Likert scale.

The questionnaire in the present study included five response options ranging from ‘Strongly disagree’ to ‘Strongly agree’ with the semantic midpoint anchor, ‘No opinion’. The instrument also afforded respondents additional opportunities to provide free response information.

⁴⁵ Carl J Chimi and David L Russell, ‘The Likert Scale: A Proposal for Improvement Using Quasi-Continuous Variables’ (2009) *Proceedings Information Systems Education Conference*, 4333.

⁴⁶ Rensis Likert, ‘A technique for the measurement of attitudes’ (1932) 22 *Archives of Psychology* 55.

⁴⁷ Chien-Ho Wu, ‘An empirical study on the transformation of Likert-scale data to numerical scores’ (2007) 1 *Applied Mathematical Sciences* 2851.

4.2.1 The midpoint

The most contentious issue in the literature on constructing a questionnaire is whether it is desirable to include a fulcrum on a see saw rating scale⁴⁸ – a midpoint.⁴⁹ Likert had originally labeled the midpoint ‘undecided’ however the more commonly accepted view is the midpoint response provides the respondent with the opportunity to express a truly neutral position: the respondent neither agrees nor disagrees with the statement.⁵⁰ The purpose of the midpoint is to avoid forcing respondents to express a non-existent opinion and reduce the risk to data quality by deterring random choices of agreement or disagreement.⁵¹ While there is a case for forcing respondents to take a substantive position as some respondents use the midpoint to avoid providing what they believe to be less than socially acceptable answers,⁵² evidence suggests that when the midpoint is omitted, respondents move to the positive or negative end of the scale according to the specific content of the survey.⁵³

Being politically correct, or telling the researcher what the respondent thinks that they want to hear in a survey of attitudes toward people with mental illness, is more likely to weigh forced responses toward the positive end of the scale, particularly as the survey is conducted in a centre for learning amongst future legal professionals. In practice, respondents will interpret the midpoint in different ways making midpoints compatible, both with ambivalence (i.e. definite but mixed feelings) and indifference (i.e. no particular feelings about the statement).⁵⁴ The numerical data is unable to sufficiently account for the reasons why a respondent chose the midpoint option but whatever the reason, it will fall within one of two categories: true neutrals or non-responses.⁵⁵

⁴⁸ Chester H McCall, ‘An empirical examination of the Likert scale: Some assumptions, developments, and cautions’ (Paper presented at the 80th Annual CERA Conference, South Lake Tahoe, CA, November 15-16, 2001) <<http://faculty.pepperdine.edu/cmccall/CERAFinal.pdf>>.

⁴⁹ Ron Garland, ‘The Mid-Point on a Rating Scale: Is it Desirable?’ (1991) 2 *Marketing Bulletin* 66.

⁵⁰ Quinten A W Raaijmakers *et al.*, ‘Adolescents’ Midpoint Responses on Likert-Type Scale Item: Neutral or Missing Values?’ (2000) 12 *International Journal of Public Opinion Research* 208.

⁵¹ Rob Johns, ‘Likert Items and Scales’ (Survey Question Bank: Methods Fact Sheet, 1 March 2010) <<http://www.surveynet.ac.uk/sqb/datacollection/likertfactsheet.pdf>>.

⁵² Robert A Johns, ‘One size doesn’t fit all: Selecting response scales for BES attitude Items’ (2005) 15 *Journal of Elections, Public Opinion and Parties* 237.

⁵³ Garland, above n 49.

⁵⁴ Johns, above n 51.

⁵⁵ Chimi and Russell, 44n 43. See also John T Kulas, Alicia A Stachowski and Brad A Haynes, ‘Middle Response Functioning in Likert-responses to Personality Items’ (2008) 22 *Journal of Business Psychology* 251.

The true neutral presupposes that the respondent has sufficient knowledge of the subject matter and has formed the belief that their response falls in the middle of the two endpoints. Respondents may default to the midpoint because (a) although knowledgeable on the subject, they are indifferent; (b) lack sufficient knowledge to know what it is that they are neutral about;⁵⁶ (c) they are unwilling to exert the effort needed to address the Item; (d) they lack the literacy or fluency skills required to comprehend the question; (e) they can feel ‘rushed’ and if a ‘bypass’ feature for the Item is not offered, can resort to the neutral simply to be finished.⁵⁷

On the other hand, the non-response respondent maybe undecided, and although unable to express a definite opinion, wants to provide a genuine response. Or it may indicate carelessness, confusion or intentional behaviour; a random guess or an omission; a systemic but irrelevant response that is non-informative about the attribute of interest; a deliberate effort to present certain impression or some unconscious stable response-style such as leniency, neutrality or an acquiescent response tendency. It may also mean ‘never thought about it’, ‘don’t know’ and ‘have no opinion’.⁵⁸

4.2.2 The midpoint for young people

When providing a response to questions of attitude, the respondent must either compute an evaluative judgment, or simply retrieve one. The younger the person, the less likely it is that they will retrieve an already formed opinion. The decision to include a midpoint response on the questionnaire was informed by the fact that a higher proportion of young people compared to adults are, in fact, ‘undecided’, having not as yet formed an opinion. Knowledge involvement is essential because it is associated with a respondent’s willingness to move on to expressing a substantive preference.

A longitudinal study of Dutch youth aged 12-24 years investigating whether young people’s midpoint responses reflected non-responses in the sense of being

⁵⁶ Chimi, above n 45.

⁵⁷ Ibid.

⁵⁸ Kathy E Green, Gary Allen and Tony CM Lam, ‘Is Neutral on a Likert Scale the Same As “Don’t Know” For Informed and Uninformed Respondents? Effects of Serial Position and Labelling on Selection of Response Options, Paper presented at the National Council on Measurement in Education, Denver, CO, May 2010.

undecided found this to be the case.⁵⁹ While the youngest respondents gave far more ‘don’t know’ responses, the use of this option decreased as they got older and a simultaneous increase occurred in the number of ‘undecided’ midpoint responses. Younger people will use the midpoint when there isn’t an alternative response of ‘don’t know’, however, when offered an explicit midpoint, respondents give fewer ‘don’t know’ responses.⁶⁰ For this reason, the midpoint on the UTAS questionnaire was titled ‘No opinion’ with the intention of directing respondents to the option if they had, in fact, not formed an opinion.

The age demographic for the current study was that 90% of respondents in the first year cohort and 85% of the final year group were aged below 24 years. The vast majority of first year respondents were between the ages of 17 and 19 while the greater proportion of the final years was aged between 22 and 24. The variances based on age groupings in the Dutch study demonstrated that the pattern of age does affect midpoint responses, and that the presence of a midpoint is valuable in mapping the shifts from non-substantive responses to substantive responses in young people as they age.⁶¹ As it was assumed that for many of the respondents, there was insufficient knowledge on which to form a substantive opinion, the researcher’s preference⁶² was to give the young people the option of declaring that they were undecided rather than forcing from them potentially ill formed, false or socially desirable substantive responses.

4.2.3 Socially Desirable Responses

A significant reporting error affecting statistical inference is socially desirable responding (SDR) which is the tendency of respondents to project favourable images of themselves.⁶³ SDR is most likely to occur in response to socially sensitive questions⁶⁴ which respondents answer through a filter of concern as to what will best depict them in a positive light or in a way that they presume to be most acceptable to the researcher. Motivations for providing dishonest or

⁵⁹ Raaijmakers, above n 50.

⁶⁰ Ibid.

⁶¹ Ibid.

⁶² Garland, above n 49.

⁶³ Timothy P Johnson and Michael Fendrich, ‘A validation of the Crowne-Marlowe Social Desirability Scale’ (Paper Presented at the 57th Annual Meeting of the American Association for Public Opinion Research, St. Pete Beach, FL, 2002) <<http://www.srl.uic.edu/publist/Conference/crownemarlowe.pdf>>.

⁶⁴ Maryon F King and Gordon C Bruner, ‘Social desirability bias: a neglected aspect of validity testing’ (2000) 17 *Psychology and Marketing* 79.

inaccurate SDR responses are (1) the need to respond in culturally sanctioned ways in order to obtain social approval;⁶⁵ (2) the inclination to say, or admit to, only good things about oneself;⁶⁶ and (3) the tendency to offer 'socially approved responses as an interaction strategy characterised by responding in normatively correct and conformist ways and generally trying to present a good face.'⁶⁷ If respondents think that they may be met with social disapproval, they will tailor their answers in a way that is consistent with popular or positive opinion. They may even believe the information they report (self-deception), or they may 'fake good' to conform to socially acceptable values, avoid criticism, or gain social approval.⁶⁸

4.2.4. Acquiescence bias

Another issue for the researcher was acquiescence bias, which is characterised as uncritical agreement by respondents who although attentive, select agreement responses regardless of Item content. Although acquiescence may result from a number of psychological, social and cultural factors, supporters of the 'Spinozan' dual model of belief⁶⁹ promote the theory that propositions are believed upon comprehension and disbelieved during a subsequent evaluation stage. This suggests that the underlying cognitive process of acquiescence lies in the initial comprehension of the statement which invokes automatic acceptance of its content.⁷⁰

The acquiescent respondent omits the second stage of evaluation, failing to retrieve relevant, and potentially contraindicating, information. The automatic acceptance does not depend on Item polarity, therefore, there are no comprehension based differences between negative and positive acquiescence. An acquiescence response does not distinguish between true and false Items. Some people are predisposed to agree or disagree in which case, their acquiescence response sets are the

⁶⁵ Timothy P Johnson, Michael Fendrich and Mary Ellen Mackesy-Amiti, 'An evaluation of the validity of the Crowne-Marlowe need for approval scale' (2012) 46 *Quality & Quantity* 1883.

⁶⁶ Derek L Phillips and Kevin J Clancy, 'Response Biases in Field Studies of Mental Illness' (1970) 35 *American Sociological Review* 503.

⁶⁷ Catherine E Ross and John Mirowsky, 'The worst place and the best face' (1983) 62 *Social Forces* 529, 530. 'Face,' says Goffman, 'is an image of self delineated in terms of approved social attributes'.

⁶⁸ King and Bruner, above n 64. Also Ted G Harvey, 'Comment on Response Biases in Field Studies of Mental Illness' (1971) 36 *American Sociological Review* 510.

⁶⁹ Daniel T Gilbert, 'How Mental Systems Believe' (1991) 46 *American Psychologist* 107.

⁷⁰ Eric S Knowles and Christopher A Condon, 'Why People Say 'Yes': A Dual-Process Theory of Acquiescence' (1999) 77 *Journal of Personality and Social Psychology* 379. See also Eric S Knowles and Nathan T Kobi, 'Acquiescent responding in self-reports: Cognitive style or social concern?' (1997) 31 *Journal of Research in Personality* 293.

manifestations of their personality type⁷¹ which are categorised into four groups: (1) yea-sayers who score high on both negative and positive Items; (2) nay-sayers who score low on both negative and positive Items; (3) assenters who score high on positive Items and low on negative Items; and (4) dissenters who score low on positive Items and high on negative Items.⁷²

Other sources of acquiescence bias are response pattern anxiety and central tendency bias. In the response pattern anxiety situation, the respondent becomes anxious about repeating the same responses and will break up the emerging pattern by inserting different responses. Respondents demonstrating central tendency bias (end aversion bias) naturally avoid using extreme response categories, preferring instead, to provide ‘middle-of-the-road’ albeit, inaccurate response. These forms of responses are a reaction to a response pattern or a reflection of the respondent’s preference to ‘play it safe’. They do not reflect the respondent’s true attitudes, thereby limiting the insightfulness of the responses.

4.3 Minimising acquiescence bias and socially desirable responses

To minimise acquiescence bias and socially desirable responses the structure of the questionnaire was designed so that positive and negative Likert Items were randomly presented on each question page. Respondents were required to cross between linguistic affirmations and negations. For example, an affirmative statement such as ‘Mentally ill clients can instruct their lawyer just fine’ was followed further down the page by the negation, ‘Mentally ill clients are unable to instruct their lawyer’.

4.4 Research questions

The first research question was whether the reported attitudes and beliefs of the law student sample would reasonably match other research findings that indicate that the general population holds stigmatised and prejudiced (sanist) perceptions about people who experience mental illness.⁷³ The second research question focused on

⁷¹ Arthur Couch, Kenneth Keniston, ‘Yeasayers and naysayers: Agreeing response set as a personality variable’ (1960) 60 *Journal of Abnormal and Social Psychology* 151.

⁷² Gary M Maranell, *Scaling: A Sourcebook for Behavioral Scientists* (Transaction Publishers, 2009).

⁷³ This thesis and its research study use ‘mental illness’ as a broad umbrella term to encompass the range of mind-related states and behavioural disturbances that attract stigma and discrimination. See Chapter One for a fuller discussion on its meaning.

whether the final year cohort would report more sanist attitudes when compared with the first year cohort. It was anticipated that the final years would exhibit more authoritarian, treatment focused, and socially restrictive attitudes due to their study of legal concepts such as compulsion and restriction, capacity, violence, public protection and criminal law insanity, and because the literature on Social Dominance Orientation attributes greater prejudice to upper level study. The final year data was also analysed for differences between respondents who identified as having a personal experience of mental illness to determine whether they reported less sanist attitudes than the group who did not identify.

The third research question examined whether the reported views of final year students who identified as having participated in the MHTRS were more positive than the reported views of the final year non-participant group. It was posited that as a consequence of the specialist therapeutic jurisprudence training, and the personal contact with clients that the MHTRS participants had experienced, they would report less authoritative, fearful and socially restrictive attitudes and more rights focused, therapeutic, socially inclusive views founded on principles of fairness, equality and justice.

4.5 Implementation of the instrument

The instrument was designed to inform this, and another research project. Although administered together, the projects were separate and distinct. For this study, 204 first year students completed the questionnaire at a point four weeks after their entry into legal education while 81 final year law students completed the questionnaire at a point four weeks prior to their departure from legal education. Participants responded in two domain areas, each including a stem statement with approximately 20 Item responses relevant to the study (See Appendices 1 and 2). The first statement had Items specific to attitudes toward people experiencing mental illness generally while the second statement related specifically to legal clients experiencing mental illness. The last page of the instrument included five additional questions with three additional statements. These provided the researcher with both quantitative and qualitative data intended to measure prejudice, social distance, familiarity and mental health literacy (See Appendix 3).

Respondents were recruited from the undergraduate cohort at the University of Tasmania (UTAS) School of Law. Tasmania is an Australian state categorised as a regional area with a dispersed population of just over 500,000. UTAS is the state's only university and in 2010, it had approximately 25,000 student enrolments overall including more than 3000 international students. All new law students at UTAS are required to enrol in the unit 'Introduction to Law 121'. In 2010, there were 301 enrolled students indicating a response rate of 67%. There were 134 final year students enrolled of whom 81 completed the survey. This indicated a response rate of 60%.

Students were given the opportunity to complete the survey during the last 20 minutes of their scheduled lecture period. They were informed that completing the anonymous survey was voluntary and unconnected to their legal course. Students who did not wish to complete the survey were advised that they could leave the auditorium. Students were told the purpose of the study and advised of their rights, particularly their right to consent which was also detailed in the Participant Information Sheet (See Appendix 7), which accompanied each questionnaire. Participants were given a short explanation of socially desirable reporting and the negative influence it can have on research results. A financial incentive was offered. Students who chose to include their student ID number on the front of the survey were placed into the draw for a \$200 book gift voucher (first year students) and four \$50 cash draws (final year students). Procedures were stringently followed to ensure that anonymity was maintained throughout the 'draw' process. The study was approved by the the Tasmania Social Sciences Human Research Ethics Committee (H11049).

5. RESULTS

Participants were categorised into different groups. The entire student cohort was labelled Group 1. After reviewing the initial results, the responses of the international participants were removed from the study. The rationale behind this decision is discussed below at 5.3. The action decreased the number of Group 1 participants from 285 to 256. Group 1 was then deconstructed into Group 2, comprising first year students (N=193) and Group 3, comprising final year students

(N=63). Group 1 responses were compared by gender. Group 2 and Group 3 responses were then compared with the aim of determining whether there were noteworthy differences in Group 3's attitudes as a result of variables such as additional education, maturation, and greater life experiences. The Group 3 responses were further analysed based on (a) gender; (b) identification with having experienced a mental illness; and (c) participation in the MHTRS.

A number of precautions were taken to prepare the data for analysis. The categories for the most part were collapsed for analysis into a trichotomous model: 'Strongly agree' and 'Agree' were combined as were 'Strongly disagree' and 'Disagree' while the 'No opinion' response remained a separate category and was excluded. Although the collapsing of data into fewer response categories infringes methodological conventions about questionnaire data, there are fundamental issues with the problematic measurement properties of multi-choice response categories per Item. This has given rise to different assumptions about the measurement properties, resulting in conflicting 'rules of thumb' for analysing Likert data.⁷⁴

There is a tendency to interpret an ordinal scale as an equal unit scale so that 'Strongly agree' is thought of as a response which is 'twice as much' as 'Agree' even though there is no way of measuring how much stronger 'Strongly agree' reflects the respondent's opinion. The strategy to collapse the response categories is based on the belief that it improves the intelligibility of the outcomes of analysis because Likert Items are not interval data and the interval between levels remains uncertain and unquantifiable.⁷⁵ Data-slicing in this way can facilitate dynamic inferences about the data.⁷⁶ There is also a real potential that the existence of actual differences will not show up if Likert scores are summed or averaged. The decision to use percentages made it easier to assess the real implications of the Item because the differences across the responses could be clearly identified.⁷⁷

⁷⁴ Peter Grimbeek *et al.*, 'Use of data collapsing strategies to identify latent variables in questionnaire data: Strategic management of junior and middle school data on the CHP questionnaire' (Paper presented at the Proceedings of the 3rd Annual International Conference on Cognition, Language and Special Education, Griffith University Gold Coast, Queensland, 2005) <<http://www.grimbeek.com.au/Papers/CHP%20instrument.pdf>>.

⁷⁵ Ibid.

⁷⁶ Ibid.

⁷⁷ Ibid

5.1 Demographic characteristics of the participants

First year participants were recruited from the compulsory, ‘Introduction to Law 121’ unit. Final year participants were recruited from the compulsory ‘Criminal and Civil Procedure 423’ unit. As noted previously, there was a response rate of over 60% for both groups. Table 1 presents the main demographic characteristics of the first and final year cohort.

5.2 Gender, age and degree

The percentage of females graduating law in Australia in 2010 was estimated at 60%.⁷⁸ As Table 1 indicates, the UTAS numbers were situated alongside the national statistic with females comprising 61% of the first year cohort and 63% of the final year cohort. As expected, the overwhelming majority of first year respondents (90%) and final year respondents (80%) were under the age of 24. The 10% variation can be explained by the number of final year students achieving their 24th birthday during their undergraduate course. More than half (53%) of the first year participants were enrolled in Arts/Law in contrast to 39% of final year participants.

Table 1 – Demographics of study participants				
Academic Year	1 st Year	Final Year	Total	
First year	204	81	285	
Sex				
Female	124	49	173	
Male	80	29	109	
Not recorded	0	3	3	
Age				
17-24	184	69	253	
25-39	15	7	22	
40-55	5	2	7	
over 55	0	0	0	
Not recorded	0	3	3	
Student Status				
Domestic student	193	63	156	
Overseas student	11	15	26	
Not recorded	0	3	3	
Degree Type				
Arts/Law	107	29	136	
Com/Law, Econ/Law Straight law	60	41	101	
Science/Law, other	36	5	41	
Not recorded	1	6	7	

• Source: Computer file, Law Faculty, UTAS

5.3 International students

Of the 204 first year respondents, 11 were international students while 15 international students were included in the 81 final year students who completed the survey. The study had not intended to focus solely on domestic student responses but an initial examination of the results indicated that the international students represented an Asian cultural group, which held different views on mental illness to

⁷⁸ In 2010, the NSW Women Lawyers puts the portion of female law graduates at 60%, ‘Women leading with the law’, *Lawyers Weekly*, 10 March 2011 <<http://www.lawyersweekly.com.au/news/women-leading-with-the-law>>.

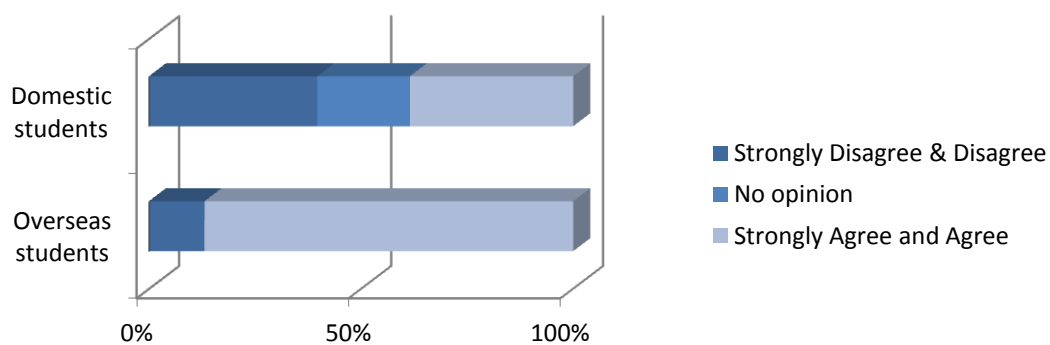
those of the domestic student group. A selection of the international student responses in contrast to domestic student responses is presented in Table 2 below.

Table 2 – Participant numbers and percentages				
- ‘strongly agreed’ and ‘agreed’ to statements that the mentally ill are:				
	Morally weak	Uneducated	Unintelligent	Dangerous
	n %	n %	n %	n %
Domestic n63	0 0	2 10	3 15	6 11
International n15	3 33	2 19	9 78	5 40

Source: Computer file, Law Faculty, UTAS

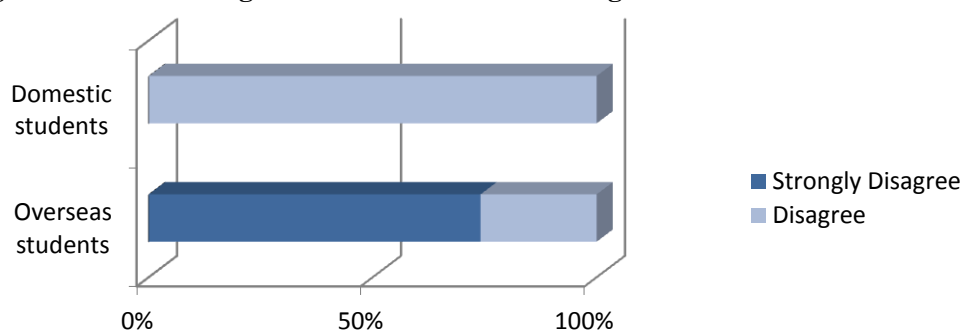
Table 2 indicates that the international respondents were much more likely to (a) view people experiencing mental illness as morally weak, uneducated and unintelligent and (b) more dangerous than the domestic respondents. Figure 1a shows that the international students have largely stereotyped clients with a mental illness as ‘difficult’. The data showed that they perceived their clients as generally lacking in cognitive and functional abilities sufficient to enable them to assist their lawyer, and that they required others to make their decisions for them.

Figure 1a – MI legal clients would be difficult to represent



Source: Computer file, Law Faculty, UTAS

Figure 1b shows the strength of disbelief of the statements that people who experience a mental illness are, generally, stigmatised and discriminated against between domestic and international students.

Figure 1b – MI are stigmatised and discriminated against

Source: Computer file, Law Faculty, UTAS

The data showed a slight trend indicating that international students were more paternalistic and authoritarian; although admittedly, this was not statistically significant, but was likely due to the small sample size $N=15$. It did raise the concern, however, that what was being measured was cultural difference, which was not an intention of the study. As a result, the decision was made to cut the 11 international respondents from Group 2 and the 15 international respondents from Group 3.

5.4 No opinion

The rationale for providing respondents with the option of a 'No opinion' midpoint was discussed above at 4.2.1. Table 3, below, reports the percentages of respondents who reported ('No opinion') on the Likert scales. Although very few participants reported 'No opinion' to IA13 ('the mentally ill have rights that must be protected'), for the bulk of Items between 15%-30% of the participants reported 'No opinion'; the rate for a handful of Items was as high as 40% and 50%. Of the 41 Items, the 1st years expressed sentiments of 'No opinion' greater than 25% at 26 Items. The final years recorded 'No opinion' sentiments greater than 25% at 18 of the 41 Items. The final year respondents were more opinionated than their first year counterparts. The preponderance of 'No opinion' responses, particularly amongst the 1st year cohort, was not an unexpected finding. Given the literature on the value of 'No opinion' for young cohorts (discussed above at 4.2.2), it was anticipated that many of the participants – aged largely between 17 to 24 – would be undecided on the issues raised in the questionnaire, or would not have formed a substantive opinion because of their lack of knowledge of the subject.

Table 3 – Percentage of ‘No opinion’ responses to all Items by 1st year and Final year students

Items	GENERALLY, the mentally ill	‘No opinion’ responses %		Items	GENERALLY, mentally ill legal clients	‘No opinion’ responses %	
		1 st Year (N=193)	Final Year (N=63)			1 st Year (N=193)	Final Year (N=63)
IA1	should be treated differently to other people	12	18	IB1	would be difficult clients for lawyers to represent	13	10.5
IA2	can’t look after themselves properly	27.5	29	IB2	would be unable to properly instruct their lawyer	28.5	23
IA3	behave badly in public	26	18	IB3	could help in developing their case strategy	36.5	34
IA4	are treated equally and fairly by the law	34	22	IB4	should do what their lawyers tells them	31	28
IA5	are dangerous	27.5	22	IB5	would find the law too complicated to understand	33	32
IA6	need doctors to make decisions for them	28.5	18	IB6	always have their rights respected	29	21
IA7	are stigmatised and discriminated against	15.5	13.21	IB7	would need their behaviour controlled by their lawyer	34	19
IA8	should be in psych hospitals and asylums	16.5	12	IB8	want what is often not a medically good option for them	38.5	43.5
IA9	don’t know right from wrong	27.5	24	IB9	can instruct their lawyers just fine	49	43.5
IA10	can’t make rational decisions	31.5	23	IB10	know that their lawyer only acts in their best interests	40	46
IA11	want to live together in hospitals instead of living in the community	15.5	8.5	IB11	lack the ability to know what is their own best interests	37	49
IA12	are erratic and emotionally unstable	35	27	IB12	have to be treated differently to other types of legal clients	22.5	20
IA13	have rights that must be protected	4	3.5	IB13	trust their lawyers	54	53.5
IA14	need to be controlled by laws	34	29	IB14	just want someone to help them	19	12.5
IA15	are treated badly by the media	25	21	IB15	are dangerous and put their lawyer’s safety at risk	22.5	24
IA16	need to be protected	21.5	12.5	IB16	are labeled and judged unfairly	20	31
IA17	commit crimes	38.5	42	IB17	should be able to get a lawyer for free	25	26.5
IA18	need their own special laws	27.5	19	IB18	don’t really know what is going on anyway	26	30.5
IA19	are morally weak	22.5	15	IB19	don’t listen well	33	45
IA20	lack intelligence and uneducated	19.5	21				
IA21	scare me	22	31				
IA22	are unpredictable	29.5	28.5		Source: Computer file, Law Faculty, UTAS		

5.5 Agreement and disagreement

In examining the responses where an opinion was recorded, two steps were taken. First, the 'No opinion' responses were excluded. Secondly, the percentage opinion results were then examined using the trichotomous model of collapsed categories that was discussed above at Section 5.0. When Likert scores are summed or averaged, there is the potential that actual differences will not be detected. By combining 'Strongly Agree' and 'Agree', and, 'Strongly Disagree' and 'Disagree', the intelligibility of the data can be improved, and dynamic inferences about the data can be made. Percentages are reported below to make it easier to identify trends in the data and differences between groups of survey respondents.

5.6 Research question 1 - Are law students prejudiced toward people who experience mental illness?

As outlined above at Section 4.1, a questionnaire was completed by 285 (204 first years and 81 final year) law students. After the international cohort was removed from the data, the responses of 193 first year and 63 final year participants (n=256) were analysed for the purpose of this study. A total of forty one Items with Likert scales were used to gauge the cohort's perceptions of two issues: (a) people who have a mental illness generally, and (b) legal clients who have a mental illness, specifically. Table 3 presents the 'No opinion' responses. Tables 4 and 5 present the reported 'Agreement' and 'Disagreement' Item percentages which have been broken down by gender. Gender is discussed more particularly below at Section 5.6.4. The results of the 41 Likert Items are presented below at Sections 5.6.1 and 5.6.2. The following Section 5.6.3, presents the results of the final page of the instrument, which incorporated multi choice and free response options (quantitative and qualitative). The data was also analysed using the gender variable and is discussed at Section 5.6.4.

5.6.1 Group 1 responses: Likert Items regarding 'people with mental illness'

Table 4 consists of 22 Items relating to general perceptions of people who experience mental illness. The 1st year respondents reported 'No opinion' responses greater than 25% in 12 out of the 22 Items and the final years in 6 out of 22 Items) (See Table 3 above).

Table 4 – Percentage of ‘Agreement’ and ‘Disagreement’ responses by 1st year and Final year students by gender (total females = 158, total males = 98)

GENERALLY, the ‘mentally ill’		Females Agree %	Males Agree %	Total Agree %	Females Disagree %	Males Disagree %	Total Disagree %
IC1	should be treated differently to other people	31	46	38.5	52.5	34.5	43.5
IC2	can’t look after themselves properly	21.5	29.5	25.5	55	38	46.5
IC3	behave badly in public	4.5	9	7	70	65	67.5
IC4	are treated equally and fairly by the law	20	23.5	22	47.5	43	45
IC5	are dangerous	5.5	10	8	65	64	64.5
IC6	need doctors to make decisions for them	7	13	10	63	60	61.5
IC7	are stigmatised and discriminated against	76	71.5	74	11	11	1
IC8	should be in psych hospitals and asylums	2	5	3.5	85	74.5	80
IC9	don’t know right from wrong	11	11	11	65	56	60.5
IC10	can’t make rational decisions	20	21.5	21	50	46	48
IC11	want to live together in hospitals instead of living in the community	0.5	5	3	83	80.5	82
IC12	are erratic and emotionally unstable	22	22.5	22	46	41	43.5
IC13	have rights that must be protected	95	91	93	1	4	2.5
IC14	need to be controlled by laws	16.5	29.5	23	43.5	41	42
IC15	are treated badly by the media	54.5	48	51	18.5	30.5	24.5
IC16	need to be protected	76.5	68.5	72.5	22	29.5	26
IC17	commit crimes	19	21.5	20	42.5	44.5	43.5
IC18	need their own special laws	13	20.5	17	59.5	52	56
IC19	are morally weak	7.5	6	7	73	68.5	71
IC20	lack intelligence and uneducated	4	12	8	76.5	64	70
IC21	scare me	10	10	10	70	58	64
IC22	are unpredictable	40.5	42	41	28	24.5	27

Source: Computer file, Law Faculty, UTAS

As discussed above at Section 4.1, the factor analysis done by Cohen and Struening in their Opinions about Mental Illness (OMI) study⁷⁹ showed that of the five factors - authoritarianism, benevolence, mental hygiene ideology, social restrictiveness and interpersonal etiology - authoritarianism and benevolence, which are now

⁷⁹ Cohen, above n 31.

considered to be prejudices, recorded the greatest variance.⁸⁰ This same pattern is observed in Table 4 where the responses indicate strong authoritarian and benevolent attitudes. Three quarters of respondents reported agreeing that people with mental illnesses need to be protected (IC16) and 38.5 % agreed that they should be treated differently to other people (IC1). Furthermore, 23% reported that they needed to be controlled by laws (IC14) and 17% thought that they should have their own special laws (IC18).

The concepts of difference, inferiority and incapability were consistently apparent throughout the data. One in four reported that people experiencing a mental illness cannot look after themselves properly (IC2) and 18% considered that they are unable to make rational decisions (IC10). A fifth of the respondents categorised them as criminal, twice the number of a recent Dutch study⁸¹ while 22% thought that they are erratic and emotionally unstable (IC12). Seven percent blamed the person for their illness, which is a similar result to that reported in a major UK study (6%).⁸² However, in contrast to some recent studies the positive response rate of 41% to the Item of ‘unpredictable’ represents a high negative statistic.⁸³

Angermeyer, in his review of public attitude studies found that the most prevalent negative attribute attached to people with mental disorders was that they are ‘unpredictable’⁸⁴ with the statistical associations ranging across 54-85 % for schizophrenia, 28-56% for depression, and 50% for anxiety disorders.⁸⁵ In this study, 41% appears to be a comparable result, particularly as the respondents were reporting against the general term ‘mental illness’ rather than specific diagnoses. The fact that only 8% reported that they are dangerous (IC5) and 10% reported feeling scared (IC21), however, does not reflect the results of most other studies which inextricably link the public’s fear of violence to mental illness,

⁸⁰ Corrigan, above n 34, 220.

⁸¹ Job T van’t Veer, Herro F Kraan, Stans HC Drosseart, and Jacqueline M Modde, ‘Determinants that shape public attitudes towards the mentally ill’ (2006) 41 *Social psychiatry and psychiatric epidemiology* 310.

⁸² Arthur Crisp *et al.*, ‘Stigmatisation of people with mental illnesses: a follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists’ (2005) 4 *World Psychiatry* 106.

⁸³ Elaine Brohan, Claire Henderson, Kirsty Little and Graham Thornicroft, ‘Employees with mental health problems: survey of UK employers’ knowledge, attitudes and workplace practices’ (2010) 19 *Epidemiol Psichiatria Sociale* 326.

⁸⁴ Matthias C Angermeyer and Sandra Dietrich, ‘Public beliefs about and attitudes towards people with mental illness: a review of population studies’ (2005) 113 *Acta Psychiatrica Scandinavica* 163.

⁸⁵ *Ibid* 170.

dangerousness and unpredictability.⁸⁶ For example, Phelan found that 59% of respondents thought that it was definitely, or probably, true that 'it's only natural to be afraid of a person who is mentally ill'⁸⁷ while 27% of Canadians reported being fearful of being around people suffering a serious mental illness.⁸⁸ This point is examined further at Section 5.6.3 where the free text qualitative survey responses are discussed.

5.6.2 Group 1 responses: Likert Items 'legal clients with mental illness'

Nineteen Items in the questionnaire focused on lawyers interacting with clients with mental illnesses. The likelihood that respondents had not worked in a legal capacity with clients experiencing mental illness resulted in the unsurprising assessment that the responses tended heavily towards 'No opinion' (See Sections 4.2 and 5.4. above). The 1st year respondents reported 'No opinion' responses greater than 25% in 14 out of the 19 Items and the final years in 12 out of 19 Items) (See Table 3 above). With regards to Table 5, even though there was a high overall percentage of 'No opinion' responses, two thirds of respondents (67.5%) stereotypically reported that they believed that people with mental illness would be difficult clients (ID1). Twenty percent disagreed while only 12.5% reported having 'No opinion' (ID1).

Table 5 suggests that the responses were consistent with Cohen and Struening's research showing a strong authoritarian trend in which clients were viewed as different, inferior and requiring restrictive and coercive handling.⁸⁹ The responses also showed a strong level of benevolence, woven within an idealistic naiveté about the lawyer client relationship held by respondents, predominantly without practical professional experience or personal contact. For example, 76% reported that clients who experience mental illness just want someone to help them (ID14); 29%

⁸⁶ Matthias C Angermeyer and Herbert Matschinger, 'Violent attacks on public figures by persons suffering from psychiatric disorders. Their effect on the social distance towards the mentally ill' (1995) 245 *European Archives of Psychiatry and Clinical Neuroscience* 159.

See also Heather Stuart, 'Violence and mental illness: an overview' (2003) 2 *World Psychiatry* 121.

⁸⁷ Jo C Phelan and Bruce G Link, 'Fear of People with Mental Illnesses: The Role of Personal and Impersonal Contact and Exposure to Threat or Harm' (2004) 45 *Journal of Health and Social Behavior* 68, 72.

⁸⁸ Canadian Medical Association, '8th Annual National Report Card on Health Care' (Report, Ipsos Reid Public Affairs, 18 August 2008)

<http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/Annual_Meeting/2008/GC_Bulletin/National_Report_Card_EN.pdf>.

⁸⁹ Cohen, above n 31.

reported that clients know that their lawyers act in their best interests (ID10); and 28% reported that clients trusted their lawyers (ID13).

Table 5 – Percentage of ‘Agreement’ and ‘Disagreement’ responses by 1st year and Final year students by gender (total females = 158, total males = 98)

GENERALLY, ‘mentally ill’ legal clients		Females Agree %	Males Agree %	Total Agree %	Females Disagree %	Males Disagree %	Total Disagree %	No opinion %
ID1	would be difficult clients for lawyers to represent	63	72	67.5	22	18.5	20	12.5
ID2	would be unable to properly instruct their lawyer	36	39	37.5	37.5	30.5	34	28.5
ID3	could help in developing their case strategy	46	44	45	15	21.5	18	37
ID4	should do what their lawyers tells them	23.5	35.5	29.5	43	36.5	37	33.5
ID5	would find the law too complicated to understand	24	36.5	30	42	29.5	36	34
ID6	always have their rights respected	24.5	24.5	24.5	49.5	45	47	28.5
ID7	would need their behaviour controlled by their lawyer	7.5	12	8	66.5	50	55.5	36.5
ID8	want what is often not a medically good option for them	23	35.5	29	32.5	27.5	30	41
ID9	can instruct their lawyers just fine	30	21.5	26	20	31.5	26	48
ID10	know that their lawyer only acts in their best interests	34	24.5	29	28.5	26.5	27.5	43.5
ID11	lack the ability to know what is their own best interests	19	22.5	21	42	34.5	38	41
ID12	have to be treated differently to other types of legal clients	50.5	58	54	26.5	19.5	23	23
ID13	trust their lawyers	25	30.5	28	17	16.5	17	55
ID14	just want someone to help them	79	73.5	76	2	9	5.5	18.5
ID15	are dangerous and put their lawyer’s safety at risk	2	2	2	76.5	71.5	74	24
ID16	are labeled and judged unfairly	61.5	52	57	14.5	24.5	19.5	23.5
ID17	should be able to get a lawyer for free	23.5	34.5	26	47	42	44.5	29.5
ID18	don’t really know what is going on anyway	6	11	8.5	64	62	63	28.5
ID19	don’t listen well	9.5	11	10	54.5	50	53	37

Source: Computer file, Law Faculty, UTAS

There was also support for the legal system’s interventionist role and the power imbalance between lawyer and client due to client difference. Stereotypically, nearly three quarters of respondents reported that clients with experience of mental illness are hard to represent (ID1) while 54% indicated that they have to be treated differently to other clients (ID12). More than a third of respondents reported that they are unable to properly instruct their lawyers (ID2), 18% reported that they are

unable to help with their case (ID3) and 29.5% indicated that they should just do what their lawyer told them to do (ID6). More than a quarter reported that clients do not want what is in their medical best interests (ID8) while more than a fifth reported that they lack the ability to know what is in their best interests (ID11). Thirty percent reported that the law is too complicated for them to understand (ID5).

In contrast to the 10% response to the general Item concerning the dangerousness of people with mental illnesses (IC5), only 2% of respondents agreed that clients with a mental illness are dangerous. A surprising result was that, although 91% agreed that people with mental illness have rights that must be protected, only a quarter of the respondents reported that they should be able to access a lawyer for free while almost half (44.5%) reported that they, in fact, should not (ID17).

An overall assessment of the first research question and the results presented in Tables 4 and 5 is that while respondents were disinclined to express opinions, when they did, they showed that law students hold stereotypical, and authoritarian and benevolently prejudicial attitudes. While there were some unexpected statistical inconsistencies with other studies, e.g. dangerousness, the level of negative attitudes is comparable, or higher, than similar global stigma research. The results tend to support Perlin's argument that the legal system is sanist because within less than a year of completing the survey, many of the respondents became practicing legal professionals.

5.6.3 Group 1 responses: multi choice and free response

As explained at Section 4.5, the final page of the survey asked participants to respond to five questions and three statements that had a mix of multi choice and free response options (See Appendix 3). Respondents provided information and description regarding performance and frequency that addressed the variables intended to measure prejudice, social distance, familiarity and mental health literacy.

Question 1 asked respondents how often they encountered media portrayals of a 'mad psycho killer' with the options of 'This week, Past month, Past year, Never and Don't remember'. Approximately half reported seeing such media coverage in

the week or month preceding completing the survey. Question 1 also allowed respondents to provide qualitative explanations of the media coverage. These responses were eclectic. No dominant themes emerged but there was a clear association between mental illness and serial offenders. The vast majority of film and television descriptions referred to the perpetrator killing, raping and kidnapping multiple times.

Question 2 asked how often respondents had read or seen a news article in which they thought that the person must have been insane to have committed such a terrible crime. Seventeen percent reported 'often' while 52.5% reported thinking so occasionally. Question 3 asked respondents to report how often they used pejorative language relating to mental illness including words such as 'loony', 'nutjob', 'wacko' and 'bananas'. Twelve percent reported using pejorative language 'often'; 36% reported using it 'occasionally'; and 37% reported using it 'rarely'. This indicates that while pejorative language was not largely reported as frequently used, 85% of respondents reported using it sometimes.

Question 4, as discussed above at Section 4.1.1, required the creation of a coding system that included four constructs (a) 'benevolence', (b) 'authoritarianism, fear and avoidance', (c) 'mental health literacy', and an additional category of (d) 'other'. The bulk of the responses fell into the 'benevolent' category. This result is consistent with Angermeyer's claim that the most common emotional response is pity.⁹⁰ Eighty percent of responses expressed sentiments of sympathy. Twenty two of 63 respondents used the word 'sympathetic'. Nine used 'sad'; eight 'vulnerable'; eight 'concerned'; six 'pitiful'; five 'sorry'; and four used the word 'helpless'. The five word strings included 'disabled - handicapped - disadvantaged - pitiful - misjudged'; 'sympathetic - empathy - concerned - vulnerable - challenging'; and 'sympathetic - helpless - emotionally unstable - do not want to be discriminated - needs lots of support'.

Many respondents chose to write statements such as: 'Don't think I can be so succinct as to put it in five words. They need help with their illness but also can't let dangerous people get away with illegal behaviour'; 'Smart in their way - friendly - have their own opinion - they feel humiliated by normal people'; 'Uncertain -

⁹⁰ Angermeyer, above n 84.

caring - scared for their well being - concerned - but they are still human'; and 'Unsure, in as in unsure of how I should interact with them - indifferent as in the way I might feel about anyone I don't know but they are still human'.

With regards to the 'authoritarian, fear and avoidance' construct, 38% of respondents used words that expressed feelings of fearfulness and avoidance toward people with mental illness. The word 'scared' was included 21 times. This is an interesting finding because it is in conflict with the Likert Item responses in which fear was not widely reported (5.6.1 and 5.6.2). This finding suggests that as many as one third of respondents associate mental illness with emotional constructs of fear/avoidance.

The 'mental health literacy' construct saw 19% of respondents' report that they were ignorant about mental illness, and that they thought they needed to be more educated. One respondent included the term 'recovery' which is the term used for the principle of recovery-oriented mental health services. Otherwise, none of the respondents expressed sentiments indicating a scientific, medical and treatment approach to people who experience mental illness. This result would suggest that the public health approach to stigma reduction has not been particularly successful amongst young adults. This is supported by the results of the 'other' construct, which was included to incorporate responses that did not fall into the three main categories.

Although unintended, what occurred was that a construct was included, which gave 19% of respondents the opportunity to expressly include disrespectful and offensive terms and strings of terms such as 'crazy - wack job - nutcase - psycho'; 'looney - loopy - bananas' and 'loony - loopy - basket case - nut - nutter'. A breakdown of the data showed that less than half of the final years (27% 1st years, 11% final years) responded in this way. The results of the 'other' construct suggests that final year students are less puerile in their reporting and may have less negative attitudes toward mental illness than 1st years.

At Question 5, of the 68.5% of respondents who reported having seen a person with mental illness in the year prior to completing the survey, the qualitative data indicated that 14% of participants reported that they knew the person had a mental

illness because of their appearance while 19% knew because of their behaviour. Six percent reported knowing because they had an aid such as a wheel chair or a carer. The data suggests that respondents hold stereotypical and prejudiced perceptions of people with a mental illness and that there is a tendency to group all disabilities (physical, intellectual, cognitive, developmental) together under the mistaken banner of mental illness. This can be seen below at Table 6, which provides examples drawn from the qualitative data. This finding supports past research that shows that young people confuse learning difficulties, physical disabilities and mental health problems.⁹¹

Table 6 Recognizing a person as ‘having a mental illness’

A sample of the responses to ‘How did you know the person had a mental illness’ included-

- Black eyes and twitching mouth
- They walked in a strange way, made tiny sounds and acted in a manner not conducive to social norms
- Looks = height, limb size
- They had all the physical features of severe autism
- Could not walk properly, tongue out etc
- The look, they were all huddled in a group with carer making loud noises
- They looked retarded
- Facial features of mild Downes Syndrome otherwise he was a happy, maybe overly excited man
- Wheelchair bound with helper/ odd look on their face
- They had a strange way about them and they lived in a supported housing establishment
- They swam for special Olympics
- She could not speak normally and she had a guardian who was guiding her in everything. She looked a bit different too
- Family friend with Downes Syndrome
- Strange look - touching young children
- Wheelchair and inability to communicate
- Very emotional eyes
- They were unable to speak, being pushed in a wheelchair
- From the look in their eyes
- They had a carer, speech difficulties
- Making an assumption based upon the fact they were gnashing their teeth and glaring at people walking by. They were also dressed in old clothing and had an unkempt appearance
- They were in a wheelchair and speaking very slowly to their mother
- They were usually disabled
- Couldn't control their actions, they were in a wheelchair.

⁹¹ Diana Rose, Graham Thornicroft, Vanessa Pinfold, and Aliya Kassam, ‘250 labels used to stigmatise people with mental illness’ (2007) 7 *BMC Health Services Research* 97.

Respondents were asked at Question 6 whether they would enter into a marriage or a civil union with a person who had a mental illness. Marriage is a well established measure for researchers assessing social distance although most researchers broaden the question to refer to a family member's marriage.⁹² Question 6 asked specifically whether the respondent would personally enter into such a committed arrangement. Twenty one percent (nearly a quarter) of respondents reported that they would not while 41.5% said that they would and 37.5% were not inclined to give an opinion. Ostensibly, these results suggest a moderate level of social distancing but it is difficult to know whether this 'liberal' view would be matched by action, or the influence that idealistic or romantic notions had on the results. This question seems particularly susceptible to the biases discussed above at Section 3.0, below and Section 6.3, above, when survey respondents are young university students.

Question 7 presented the mental health literacy question, 'Schizophrenia is an illness like any other illness such as asthma, diabetes etc'. English data gathered in 2011 indicated that 77% of the population response was in agreement with schizophrenia being an illness like any other.^{93 94} In this study, responses were divided with 36% disagreeing that schizophrenia is an illness like any other and 47% agreeing that it is.⁹⁵ These results suggest that the global public health disease approach to mental illness discussed in Chapter One has not achieved the desired success particularly amongst the educated cohort of UTAS law students.

Recent research has also shown that while there has been an increase in the public's endorsement of a biological causation for schizophrenia, it has been accompanied by parallel increases in the public's fear of, and desire for, greater social distance

⁹² Allison L Smith and Craig S Cashwell, 'Social Distance and Mental Illness: Attitudes Among Mental Health and Non-Mental Health Professionals and Trainees' (2011) 1 *The Professional Counselor* 13. See also Jennifer E Boyd, Emerald P Katz, Bruce G Link, and Jo C Phelan, 'The relationship of multiple aspects of stigma and personal contact with someone hospitalized for mental illness, in a nationally representative sample' (2010) 45 *Social psychiatry and psychiatric epidemiology* 1063. See also Matthias C Angermeyer, Herbert Matschinger and Patrick W. Corrigan, 'Familiarity with mental illness and social distance from people with schizophrenia and major depression: testing a model using data from a representative population survey' (2004) 69 *Schizophrenia research* 175. See also Matthias C Angermeyer and Herbert Matschinger, 'Social distance towards the mentally ill: results of representative surveys in the Federal Republic of Germany (1997) 27 *Psychological medicine* 131.

⁹³ Attitudes to Mental Illness - 2011 (Survey report, National Health Service, U.K., 2011) <http://www.hscic.gov.uk/catalogue/PUB00292>

⁹⁴ Bernice A Pescosolido *et al.*, '"A Disease Like Any Other"? A Decade of Change in Public Reactions to Schizophrenia, Depression, and Alcohol Dependence' (2010) 167 *American Journal of Psychiatry* 1321.

⁹⁵ President Clinton, *We must make it clear, once and for all: mental illness is no different from physical illness*, Remarks at the White House Conference on Mental Health, 1 Published Papers 896, 1.

from people with schizophrenia.⁹⁶ The fact that more than a third of respondents differentiate schizophrenia from somatic illness emphasises difference and the categorising of ‘Otherness’ which, as was discussed in Chapter Three, helps to create the image of someone who is incapable, dangerous and unpredictable: a member of a group that is marginalised, subordinated and ostracised. On the other hand, the fact that nearly half of the respondents agree that schizophrenia is ‘an illness like any other’, may, as Angermeyer suggests, be accompanied by an increased level of fear and desire for social distance. The low statistical responses from the Likert Items relevant to ‘dangerousness’ appear to conflict with this proposition.

Finally, Question 8 asked respondents ‘whether the mentally ill should be forced to take medication’. One in five respondents indicated that they should. ‘The use of legal coercion to compel individuals to participate in mental health treatment is expanding despite a lack of empirical support for many of its forms.’⁹⁷ Studies examining the public’s views on legally mandated treatment suggest that fear is a particularly strong predictor of support for coercive treatment.⁹⁸ The public levels of concern regarding ‘dangerousness’ operate to increase or decrease its level of fear.⁹⁹ A limitation for this study was that it was unable to determine whether the one fifth of respondents who agreed with forced medication did so as an indication of their intention to ‘help’ or whether it was prompted by their fear of the behavioural manifestation of people who experience mental illness. Similarly to Question 7, the low Likert ‘dangerousness’ Item suggests that fear is not a major motivator although, as previously discussed, Question 4 suggests that fear is significant in the attitudes of the respondents. A third of respondents were not inclined to answer this question. It is hoped that this study stimulates further investigation into the role of fear in developing the attitudes of law students.

⁹⁶ Matthias C Angermeyer, Herbert Matschinger and Georg Schomerus, ‘Attitudes towards psychiatric treatment and people with mental illness: changes over two decades.’ (2013) 203 *The British Journal of Psychiatry* 146.

⁹⁷ Amy C Watson, Patrick W Corrigan and Beth Angell, ‘What motivates public support for legally mandated mental health treatment?.’ (2005) 29 *Social Work Research* 87, 87.

⁹⁸ Corrigan, Patrick, Fred E. Markowitz, Amy Watson, David Rowan, and Mary Ann Kubiak. ‘An attribution model of public discrimination towards persons with mental illness’ (2003) 44 *Journal of Health and Social Behavior* 162. See also Bruce G Link, Jo C. Phelan, Michaeline Bresnahan, Ann Stueve, and Bernice A Pescosolido, ‘Public conceptions of mental illness: labels, causes, dangerousness, and social distance’ (1999) 89 *American Journal of Public Health* 1328.

⁹⁹ Corrigan, above n 98.

5.6.4 Group 1 responses by gender: *Likert Items and multi choice and free responses*

Overall, few gender differences were observed in the Group 1 Likert Item responses; a result consistent with previous studies. Some slight trends were apparent, however, when the data was examined by year groups. There were no significant differences between the responses of the males and females in the final year cohort. However, statistically significant differences were found between the males and females in the responses given by the first year cohort at 8 Items (IC1= $p<0.001$, IC2= $p<0.015$, IC14= $p<0.016$, IC15= $p<0.033$, IC20= $p<0.016$, ID5= $p<0.021$, ID7= $p<0.030$ and ID8= $p<0.054$). Regarding the stereotype that people who experience mental illness lack intelligence and are uneducated (IC20), only 4% of the first year females agreed in contrast to 16% of the males. There was less of a percentage gap between the final year females (2.6%) and the males (4%).

In 10 of the overall Group 1 Items, males appeared slightly more inclined toward controlling, authoritarian approaches while females were more benevolent in their responses. This can be noted above in Table 4 (IC1, 2, 4, 7, 14, 15, 18) and Table 5 (ID1, 6, 16). With regard to the additional eight questions included on the final page, slight trends were observed. Twenty eight percent of males reported that they would never marry someone who had a mental illness, but only 17% of female respondents. Females were also more accepting of the ‘illness like any other’ policy with 57%, agreeing that schizophrenia was like any other illness, as compared to 37.5% of males. The only finding that met statistical significance was Question 4, which required respondents to provide five words to describe their feelings about people who experienced mental illness. Chi square contingency tests indicated that compared with males, females were more likely to use words indicating sympathy, sadness and pity when reporting how they perceived people with mental illness ($p<0.01$). In percentage terms, 84% of females referred to the benevolence construct compared with 76.5% of males.

5.7 Research question 2 – Are final year law students more prejudiced toward people who experience mental illness than first year law students?

It was noted above, at Section 5.4, that a high proportion of respondents reported ‘No opinion’ in response to the questionnaire Items. Although the final year students were slightly more prepared to offer opinions than the first years, overall, the data reflected a relatively high degree of homogeneity between the two groups. Once comparison was conducted without the ‘No opinion’ responses – that is, only ‘Agree’ (compressed with ‘Strongly agree’) and ‘Disagree’ (compressed with ‘Strongly Disagree’) – the same essential pattern was observed in the data; the views of first and final year students are arguably homogenous.

Table 7, below, presents the responses of first and final year students to the Likert Items regarding more broadly, people who experience mental illness.

Table 7 – Group 1 - agreement and disagreement by year (total 1st years = 193, total Final years = 63)					
GENERALLY, the mentally ill		First years Agree %	Final years Agree %	First years Disagree %	Final years Disagree %
IE1	should be treated differently to other people	36	38	47	41
IE2	can't look after themselves properly	25	24	48.5	47.5
IE3	behave badly in public	6	6	68	70
IE6	are treated equally and fairly by the law	19	28.5	45.5	46
IE5	are dangerous	8	4.5	64	66.5
IE6	need doctors to make decisions for them	9	9.5	60.5	66.5
IE7	are stigmatised and discriminated against	74	74.5	11.5	8
IE8	should be in psych hospitals and asylums	3.5	1.5	81	81
IE9	don't know right from wrong	12	8	61	63.5
IE10	can't make rational decisions	23	12.5	45	59
IE11	want to live together in hospitals instead of living in the community	2.5	1.5	81.5	84
IE12	are erratic and emotionally unstable	25	14.5	41	54
IE13	have rights that must be protected	93	93.5	2.5	1.5
IE14	need to be controlled by laws	23	16	40.5	49
IE15	are treated badly by the media	50	56	25	39.5
IE16	need to be protected	71	81	7	3
IE17	commit crimes	20.5	17.5	41	41
IE18	need their own special laws	12	24	58.5	50.5
IE19	are morally weak	8.5	1.5	69	78
IE20	lack intelligence and uneducated	8	3	72.5	70
IE21	scare me	12	5	67.5	60.5
IE22	are unpredictable	47	22	23.5	36.5
Source: Computer file, Law Faculty, UTAS					

Of the 22 Items in Table 7, a statistically significant difference was observed in only one (IE18). This asked respondents whether they thought that people who experienced a mental illness needed their own special laws. Of the final years, 24% reported that they did, in contrast to 13.5% of the first year respondents; and 81% of the final year respondents, compared to 71% of the first years, reported that they needed to be protected (IE16). On the other hand, more than double the number of first years thought that people with a mental illness were unpredictable (IE22) and nearly double again thought them to be erratic and unstable (IE12).

With respect to the more narrow Items relevant to legal clients with mental illnesses, Table 8 (below) indicates that even fewer differences were discernible between first and final year responses.

Table 8 – Group 1 - agreement and disagreement by year (total 1st years = 193, total Final years = 63)					
GENERALLY, mentally ill legal clients		First years Agree %	Final years Agree %	First years Disagree %	Final years Disagree %
IF1	would be difficult clients for lawyers to represent	67	63.5	19.5	35
IF2	would be unable to properly instruct their lawyer	38	36.5	33.5	38
IF3	could help in developing their case strategy	43.5	55.5	18	16
IF6	should do what their lawyers tells them	30	22	39	46
IF5	would find the law too complicated to understand	29	28.5	38	39.5
IF6	always have their rights respected	24	25.5	46.5	50.5
IF7	would need their behaviour controlled by their lawyer	8	14.5	59	63.5
IF8	want what is often not a medically good option for them	31	17.5	29	35
IF9	can instruct their lawyers just fine	25	31.5	25.5	22
IF10	know that their lawyer only acts in their best interests	31	28.5	29	24
IF11	lack the ability to know what is their own best interests	23	12.5	40	36.5
IF12	have to be treated differently to other types of legal clients	51	60	26	17.5
IF13	trust their lawyers	27.5	27	16.5	17.5
IF14	just want someone to help them	75	82.5	5.5	1.5
IF15	are dangerous and put their lawyer's safety at risk	2	4.5	75.5	71.5
IF16	are labeled and judged unfairly	57.5	58.5	21	39.5
IF17	should be able to get a lawyer for free	26.5	31.5	46.5	39.5
IF18	don't really know what is going on anyway	9.5	1.5	63	63.5
IF19	don't listen well	13	1.5	53	50
Source: Computer file, Law Faculty, UTAS					

Table 8 shows that almost 40% of final year respondents reported that people experiencing a mental illness were not labeled or judged unfairly (IF16) which was nearly twice the number of the first year respondents. However, this difference did not achieve statistical significance when chi squared.

Analysing the data in Tables 7 and 8 indicates that there are no markedly different attitudes between the two cohorts of students. In terms of trends that may be of interest to future research, the 1st year respondents did report more stereotypical attitudes toward people who experience mental illness, such as that they are unstable, unpredictable and irrational. On the other hand, the final year group appeared to have a more authoritarian focus to its responses. Only 0.5% separated the groups in their disagreement with the statement that, generally, people with a mental illness are treated equally and fairly by the law (IE6). But almost double the number of final years disagreed with the statement that legal clients with a mental illness were labeled and judged unfairly (IF16) (39% compared to 21%).

5.7.1 The influence of respondent's personal experience of mental illness on data

The number one health issue facing young people aged 16-24 in Australia is mental illness with 26% affected in any year.¹⁰⁰ By age 21, just over half will have experienced a diagnosable psychiatric disorder¹⁰¹ and over 75% of common mental health problems will occur by the age of 25.¹⁰² The demographical gathering questions on the survey cover sheet asked respondents whether they had personally experienced a mental illness. The broad term, 'mental illness' was not defined. The final year cohort had an additional question asking whether, if they answered yes, the onset of the illness had occurred during their university legal studies. Of the Group 1 cohort (256), 47 respondents answered yes. Of the 63 final year respondents, 14 answered in the positive with 65% reporting that they had become ill during their academic legal studies. Seventy one percent of the positive responses were from females and 29% from males.

¹⁰⁰ Tim Slade *et al.*, 'The mental health of Australians 2: Report on the 2007 national survey of mental health and wellbeing' (Report, Department of Health and Ageing Australian Government, May 2009).

¹⁰¹ Ronald C Kessler *et al.*, 'Age of onset mental disorders: a review of recent literature' (2007) 20 *Current Opinion in Psychiatry* 359.

¹⁰² Kelk above n 14, v.

Although WHO claims that ‘Overall rates of psychiatric disorder are almost identical for men and women’,¹⁰³ this claim is strongly criticised by researchers as simply untrue, with suggestions that psychological disorders are 20% to 40% more common in women than men.¹⁰⁴ The *Courting the Blues* study reported that psychological distress was statistically higher amongst female law students¹⁰⁵ with females also more willing than males to report their illness.¹⁰⁶ The results of this study support those findings and suggest that the results may be underestimated.

Table 9 – Group 2 - Agreement and disagreement by personal experience of mental illness reporting					
Item	GENERALLY, the mentally ill	No MI N=49 Agree %	Yes MI N=14 Agree %	No MI N=49 Disagree %	Yes MI N=14 Disagree %
IG1	should be treated differently to other people	36.5	43	37	28.5
IG2	can't look after themselves properly	22.5	28.5	45	57
IG3	behave badly in public	8	0	71.5	64.5
IG6	are treated equally and fairly by the law	28.5	28.5	43	57
IG5	are dangerous	6	0	65.5	71.5
IG6	need doctors to make decisions for them	12	0	61	86
IG7	are stigmatised and discriminated against	69.5	93	10	0
IG8	should be in psych hospitals and asylums	2	0	81.5	78.5
IG9	don't know right from wrong	8	7	61	71.5
IG10	can't make rational decisions	12	14.5	55	71.5
IG11	want to live together in hospitals instead of living in the community	2	0	83.5	85.5
IG12	are erratic and emotionally unstable	14.5	14.5	59	35.5
IG13	have rights that must be protected	94	93	2	0
IG14	need to be controlled by laws	20.5	0	47	57
IG15	are treated badly by the media	57	57	16.5	21.5
IG16	need to be protected	81.5	92.5	4	0
IG17	commit crimes	16.5	21.5	39	21.5
IG18	need their own special laws	28.5	7	49	57
IG19	are morally weak	2	0	79.5	71.5
IG20	lack intelligence and uneducated	2	7	67.5	78.5
IG21	scare me	6	0	57	71.5
IG22	are unpredictable	22.5	21.5	30.5	57
Source: Computer file, Law Faculty, UTAS					

¹⁰³ Gender and women's mental health, Gender disparities and mental health: The Facts, World Health Organization, Mental Health (Fact Sheet, WHO, 2013)

http://www.who.int/mental_health/prevention/genderwomen/en/.

¹⁰⁴ Daniel Freeman and Jason Freeman, *The Stressed Sex: Uncovering the Truth About Men, Women, and Mental Health* (Oxford University Press, 2013).

¹⁰⁵ Kelk above n 14, 41.

¹⁰⁶ *Ibid*, 11.

The Chi squared test showed that there was no significant difference in the final year responses to the general Items, but statistically significant differences were found in Items regarding legal clients who experienced a mental illness (IO2; $p < 0.001$, IO3; $p < 0.05$ and IO17; $p < 0.05$). Although the group reporting having had a mental illness was small ($N=14$), slight trends in attitudinal difference were apparent in the percentages. Perhaps most appreciably, 93% of the group that reported having had a mental illness indicated that people who experience a mental illness are stigmatised and discriminated against as compared to 69.5% of the non-mental illness group (IG7). The identifying group was also 25% more inclined to disagree with the need for doctors to make decisions (IG6) as well as disagreeing with the statements that they were unable to make rational decisions (16.5% IG10); were erratic and unstable (24.5% IG12); and committed crimes (17.5% IG17). There was a noticeable trend that the participants who reported having had a mental illness appeared to be less accepting of the stereotypes than their counterparts (See Table 9 above).

With regard to the Items specific to legal clients below at Table 10, respondents who reported having had a mental illness demonstrated less stereotypical attitudes towards the functioning capabilities of clients. For example, 47% of the non-mental illness group agreed that the client would be unable to properly instruct their lawyer compared to 0% in the mental illness group (IH2) while 71.5% of the mental illness group disagreed with the statement that the client would be unable to properly instruct their lawyer compared to 28.5% in the non-mental illness group (IH2). Of the two groups, 30% more in the mental illness group reported that the client could help to develop their case strategy (IH3) and 22.5% more reported that clients should be able to access a lawyer for free (IH17). However, over half of the non-mental illness group thought that clients should not be able to access a lawyer for free compared to 14% of the mental illness group who thought they should not be able to access a lawyer for free (IH17).

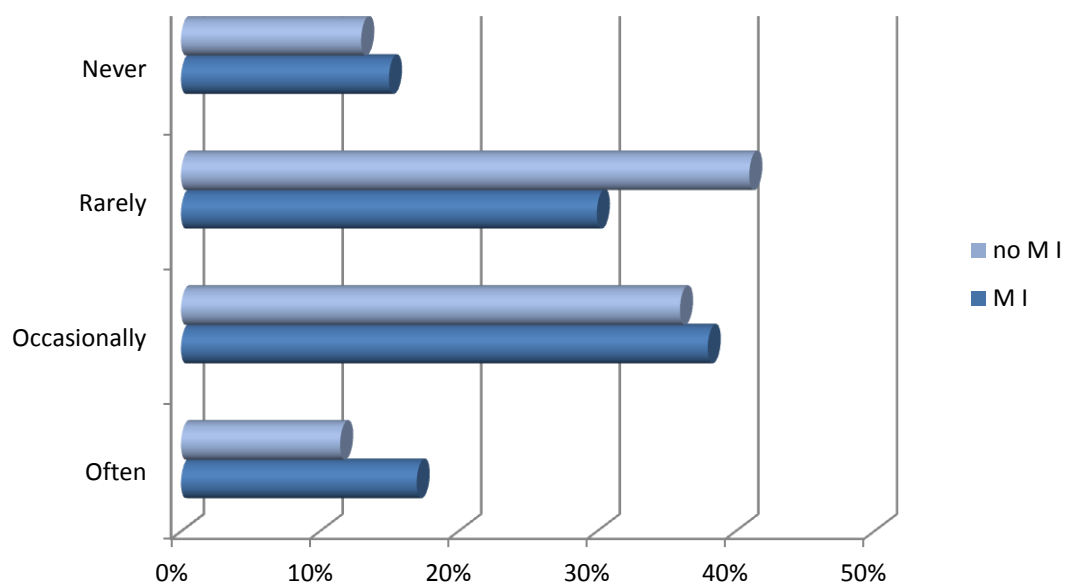
Table 10 – Group 2 - Agreement and disagreement by personal experience of mental illness reporting

Item	I think that mentally ill legal clients GENERALLY	No MI N=49 Agree %	Yes MI N=14 Agree %	No MI N=49 Disagree %	Yes MI N=14 Disagree %
IH1	would be difficult clients for lawyers to represent	65.5	57	22.5	28.5
IH2	would be unable to properly instruct their lawyer	47	0	28.5	71.5
IH3	could help in developing their case strategy	49	78.5	18.5	7
IH6	should do what their lawyers tells them	24.5	14	43	57
IH5	would find the law too complicated to understand	30.5	21.5	28.5	57
IH6	always have their rights respected	26.5	21.5	51	50
IH7	would need their behaviour controlled by their lawyer	16.5	7	61	71.5
IH8	want what is often not a medically good option for them	18.5	14.5	34.5	35.5
IH9	can instruct their lawyers just fine	28.5	35.5	20.5	28.5
IH10	know that their lawyer only acts in their best interests	28.5	28.5	18.5	43
IH11	lack the ability to know what is their own best interests	16.5	0	32.5	50
IH12	have to be treated differently to other types of legal clients	59	64.3	18.5	14.5
IH13	trust their lawyers	30.5	14.5	16.5	21.5
IH14	just want someone to help them	81.5	85.5	2	0
IH15	are dangerous and put their lawyer's safety at risk	2	0	71.5	71.5
IH16	are labeled and judged unfairly	59	58	8	14.5
IH17	should be able to get a lawyer for free	28.5	43	51	14
IH18	don't really know what is going on anyway	2	0	61	71.5
IH19	don't listen well	2	0	53	64.5
Source: Computer file, Law Faculty, UTAS					

5.7.1.1 Final page 1-8 responses

It was an unexpected result to find that at Question 3, respondents in the mental illness (MI) group reported using pejorative language more often and more occasionally than respondents in the non-mental illness (No MI) group. Thirty percent also reported using it rarely which was only slightly less than the non-mental illness group. This finding is somewhat inconsistent with the findings of a recent study indicating that people who have personal experience of mental illness have a more respectful attitude toward to others who experience mental illness.¹⁰⁷

Figure 2 – Final Page Q3 – ‘Do you use terms such as loony...’ - MI/no MI Groups



Source: Computer file, Law Faculty, UTAS

The Question 4, benevolence factor achieved significance when chi squared. Ninety six percent of the mental illness group reported more benevolent responses compared to the non-mental illness group (78%).

The Question 6, social distance responses indicated that 76.5% of the mental illness group reported that they would marry a person with a mental illness compared to 32% in the non-mental illness group. Also, 6.5% said that they would never marry a person with a mental illness in contrast to a quarter of the non-mental illness group. Fifty three percent of the mental illness group agreed that ‘schizophrenia

¹⁰⁷ Jennifer E Boyd, Emerald P Katz, Bruce G Link, and Jo C Phelan, ‘The relationship of multiple aspects of stigma and personal contact with someone hospitalized for mental illness, in a nationally representative sample’ (2010) 45 *Social psychiatry and psychiatric epidemiology* 1063.

was an illness like any other', 12% more than the no mental illness group of which, 43% also disagreed that mental illness was an illness like any other compared to 25.5% of the mental illness group, which disagreed.

5.7.2 The influence of respondent's participation in the MHTRS on data

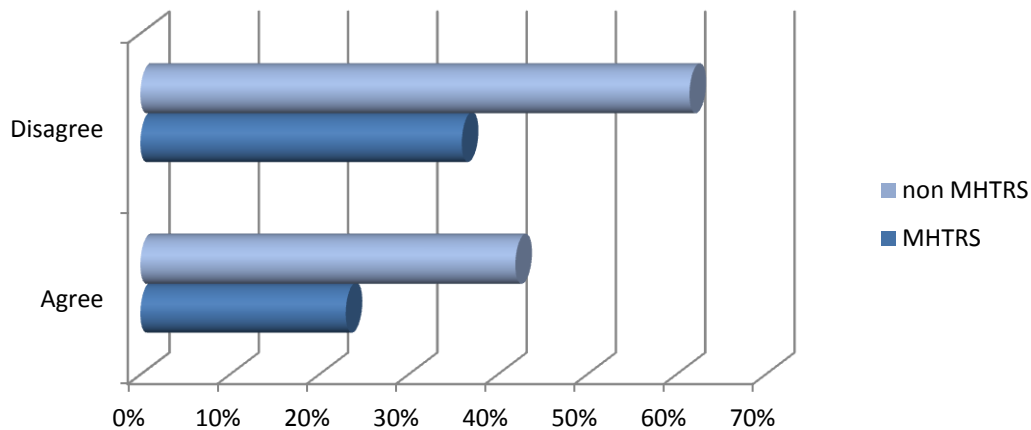
The demographic questions included whether the respondent had undertaken the MHTRS training. Respondents who replied in the affirmative were asked the additional question of whether they had gone on to represent a client before the Mental Health Tribunal (MHT). Twenty one percent (13) of Group 2 reported having completed the MHTRS training (6 males and 7 females). Five of the trained respondents represented a client before the MHTRS. The 8 respondents who did not represent a client may have had their client discharged from their order prior to the hearing, a common occurrence which was discussed in Chapter Seven; may not have yet been allocated a representation; or chose not to offer a representation service after training. The fact that it is unknown how many of the 8 actually had some level of personal contact with a client has a limiting influence on the results of the study because contact is considered to be a crucial factor in helping reduce stigma and decrease discrimination.

There was a slight difference in the number of 'No opinion' responses to the Items relating to people who experience mental illness generally. Of the group who had not done the MHTRS training, 7 of the 22 Items reported a 'No opinion' Item response greater than 25%. Of the group that had done the training, this statistic proved lower (5 of the 22 Items). With regard to the client specific Items, the participant group demonstrated a primarily 'No opinion' sentiment at 9 of the 19 Items in contrast to the non-MHTRS group's 12 Items.

The responses to the first Item at Table 11 indicating that people who experience a mental illness should be treated differently (II1) seemed to set the trend for most of the Items. The MHTRS group tended to be less authoritarian and less benevolent in their responses compared to the non-participant respondents (See Figure 3, below). The MHTRS group also reported less support of stereotypes such as at Item II22 which shows nearly 20% less agreement with the non-participant group that people who experienced mental illness are unpredictable.

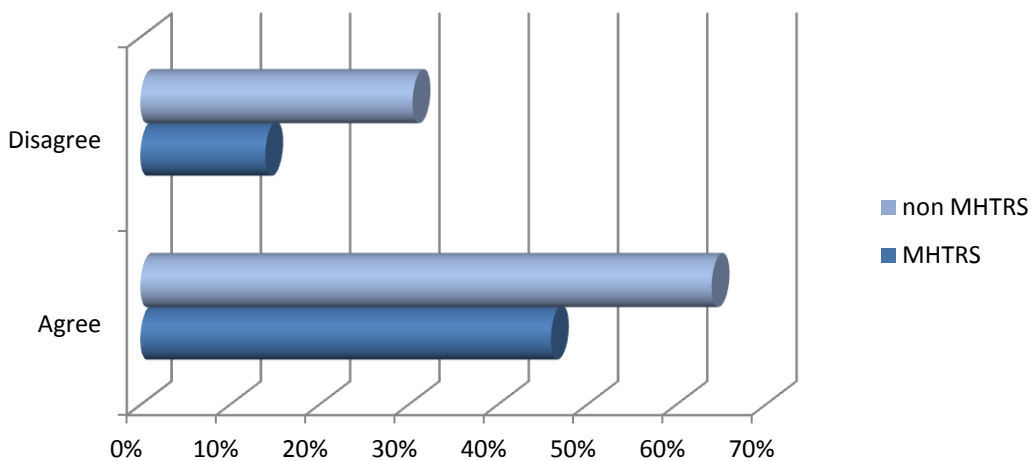
There were a few Items where a more benevolent response was indicated such as at Item II16 where 14.5% more of the participant group reported that people experiencing a mental illness should be protected and 19% more than the non-participant group reported that they thought that people experiencing a mental illness are not stigmatised and discriminated against (II7).

Table 11 – Group 2 - Agreement and disagreement by MHTRS participation					
GENERALLY, the mentally ill		N=50		N=13	
		No MHTRS Agree %	Yes MHTRS Agree %	No MHTRS Disagree %	Yes MHTRS Disagree %
II1	should be treated differently to other people	42	23	36	61.5
II2	can't look after themselves properly	22	30.5	48	46
II3	behave badly in public	8	0	70	69
II6	are treated equally and fairly by the law	26	38.5	46	46
II5	are dangerous	6	0.0	64	77
II6	need doctors to make decisions for them	10	7.5	64	77
II7	are stigmatised and discriminated against	74	77	4	23
II8	should be in psych hospitals and asylums	2	0	80	84.5
II9	don't know right from wrong	6	15.5	64	61.5
II10	can't make rational decisions	14	7.5	56	69
II11	want to live together in hospitals instead of living in the community	2	0	82	92
II12	are erratic and emotionally unstable	18	0	50	69
II13	have rights that must be protected	96	83.5	0	7.5
II14	need to be controlled by laws	16	15	50	46
II15	are treated badly by the media	54	69	16	23
II16	need to be protected	78	92.5	4	0
II17	commit crimes	20	7.5	30	54
II18	need their own special laws	24	23	52	46
II19	are morally weak	2	0	82	61.5
II20	lack intelligence and uneducated	2	0	70	69
II21	scare me	4	7.5	38	30.5
II22	are unpredictable	26	7.5	38	30.5
Source: Computer file, Law Faculty, UTAS					

Figure 3 – MI should be treated differently to other people (II1 –Table 11)

Source: Computer file, Law Faculty, UTAS

This slight trend was also noticeable at the Items specific to clients who experience a mental illness (see Table 12, below). MHTRS participants were less inclined to see the client with a mental illness as being different and requiring marginalisation (see Figure 4, below).

Figure 4 – MI legal clients should be treated differently (IJ12 Table 12)

Source: Computer file, Law Faculty, UTAS

Table 12 – Group 2 - agreement and disagreement by MHTRS participation

GENERALLY, mentally ill legal clients		N=50		N=13	
		No MHTRS Agree %	Yes MHTRS Agree %	No MHTRS Disagree %	Yes MHTRS Disagree %
IJ1	would be difficult clients for lawyers to represent	60	77	26	15
IJ2	would be unable to properly instruct their lawyer	38	31	38	38.5
IJ3	could help in developing their case strategy	56	54	16	15.5
IJ6	should do what their lawyers tells them	24	15.5	42	61.5
IJ5	would find the law too complicated to understand	30	23	32	46
IJ6	always have their rights respected	30	7.5	46	69.5
IJ7	would need their behaviour controlled by their lawyer	16	7.5	60	77
IJ8	want what is often not a medically good option for them	18	15.5	36	31
IJ9	can instruct their lawyers just fine	30	38	20	38
IJ10	know that their lawyer only acts in their best interests	30	23	20	38.5
IJ11	lack the ability to know what is their own best interests	14	7.5	34	46
IJ12	have to be treated differently to other types of legal clients	64	46	14	31
IJ13	trust their lawyers	28	23	16	23
IJ14	just want someone to help them	84	77	2	0
IJ15	are dangerous and put their lawyer's safety at risk	2	0	74	61.5
IJ16	are labeled and judged unfairly	60	54	8	15.5
IJ17	should be able to get a lawyer for free	32	30.5	38	46
IJ18	don't really know what is going on anyway	0	7.5	66	54
IJ19	don't listen well	2	0	54	38.5

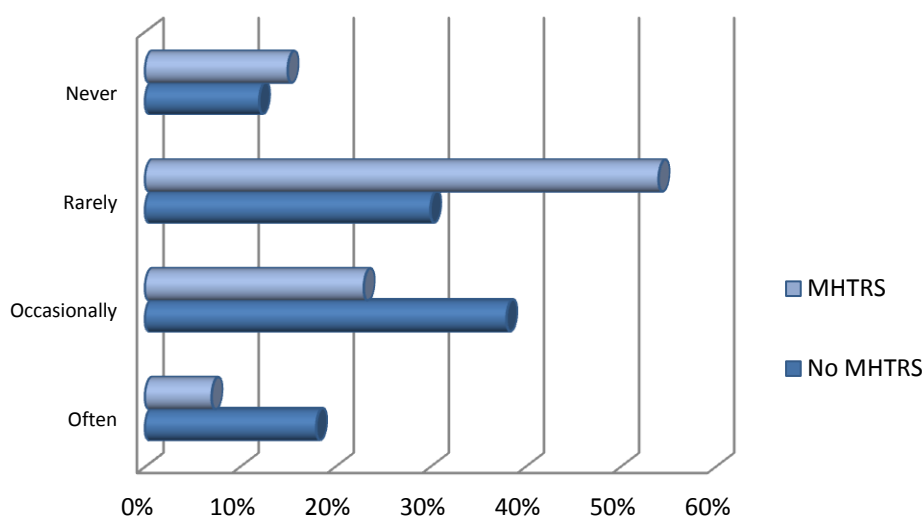
Source: Computer file, Law Faculty, UTAS

5.7.2.1 Questions 1-8 written responses

It was reported at Section 5.7.1.1 that respondents who had an experience of mental illness reported a higher tendency to use pejorative language than respondents who did not. In this instance, respondents who had participated in the MHTRS reported using pejorative language less than the non-participant group (see Figure 5, below). The analysis of Question 4 indicated that in the participant group, the benevolence factor was present 20% more (at 92%) than in the non-participant group (at 72%). The Question 4 responses also showed the mental health literacy factor present in 13% more of the responses of the participant group. This supported the Question 7

mental health literacy question which showed that 20% more MHTRS participants agreed that schizophrenia was an illness like any other (70% - 50%). The questions showed slightly higher positive responses and slightly lower negative responses from the participant group other than at Question 6 where 23% compared to 24% of the non-participant group agreed that they would never marry a person with a mental illness. However, 54% of the participant group compared to 42% disagreed with the statement.

Figure 5 – Final Page, Q3 – ‘Do you use terms such as loony...’ - MHTRS/no MHTRS Groups



Source: Computer file, Law Faculty, UTAS

6. DISCUSSION

Attitudinal research regarding mental illness has been examined extensively across western¹⁰⁸ and non-western societies.¹⁰⁹ The studies have consistently arrived at the similar finding that, generally, the public's attitudes are unfavourable. Research particular to the attitudes of law students¹¹⁰ has largely been consequential, arising out of studies primarily focused on the poor mental health status of law students.

¹⁰⁸ Corrigan *et al.*, above n 35. See also Bruce G Link *et al.*, 'Public conceptions of mental illness: labels, causes, dangerousness and social distance' (1999) 89 *American Journal of Public Health* 1328.

¹⁰⁹ Amresh Shrivastava, Megan Johnston and Yves Bureau, 'Stigma of Mental Illness-1: Clinical reflections' (2012) 10 *Mens Sana Monographs* 70. See also Ritsuko Kakuma *et al.*, 'Mental Health Stigma: What is being done to raise awareness and reduce stigma in South Africa?' (2010) 13 *African Journal of Psychiatry* 116. See also Charmaine J Hugo *et al.*, 'Community attitudes toward and knowledge of mental illness in South Africa' (2003) 38 *Social Psychiatry Psychiatric Epidemiology* 715. Also Haluk Arkar and Doğan Eker, 'Effects of psychiatric labels on attitudes toward mental illness in a Turkish sample' (1994) 40 *International Journal of Social Psychiatry* 205.

¹¹⁰ Lawrence S Krieger, 'Institutional Denial about the Dark Side of Law School, and Fresh Empirical Guidance for Constructively Breaking the Silence' (2002) 52 *Journal of Legal Education* 112. See also Kelk above n 14.

These studies indicate that students enter law school suffering from clinical stress and depression rates that mirror national averages but that the rates increase during the first year of law school and continue to rise throughout the duration of the student's legal education, and on into their professional careers. In this study, 17% of first year respondents reported having a mental illness. This increased in the final year group of whom 22% reported having experience of a mental illness. Almost two thirds (64%) indicated that their mental illness developed while they were studying law.

This study supports previous research that shows that law students experience high rates of mental illness. The research suggests that law students have clinically elevated anxiety, hostility, depression, and other psychiatric symptoms ranging across levels that are eight to fifteen times higher than the general population.¹¹¹ Law students have a twenty to forty percent incidence of clinical depression.¹¹² However, it is, usually, only when the reasons behind why law students are unwilling to access treatment for their mental health problems are discussed that the topic of stigma invariably rises as the probable cause.¹¹³

The essential focus of this thesis is an examination of the negative attitudes associated with mental illness that is, according to Perlin, so apparent in the legal system. The empirical research undertaken specifically targeted law students: the future politicians, policy-makers, legal academics, judges, lawyers and court administrators, to assess broadly their attitudes to people who experience mental illness, and more narrowly, toward legal clients who experience mental illness. To the best of our knowledge, it is the first attitudinal study that has focused on the relationship between the lawyer and their client with a mental illness. The research examined the attitudinal influences of gender; self history of mental illness; and participation in the Mental Health Tribunal Representation Scheme (MHTRS), the therapeutic jurisprudence clinical legal education program discussed in Chapter Seven. In a number of respects, the results delivered in this chapter were somewhat

¹¹¹ Stephen B Shanfield and G Andrew H Benjamin, 'Psychiatric Distress in Law Students' (1985) 35 *Journal of Legal Education* 65.

¹¹² Matthew M Dammeyer and Narina Nunez, 'Anxiety and Depression among Law Students: Current Knowledge and Future Directions' (1999) 23 *Law and Human Behavior* 55. See also Ruth Ann McKinney, 'Depression and Anxiety in Law Students: Are We Part of the Problem and Can We Be Part of the Solution' (2002) 8 *The Journal of the Legal Writing Institute* 229.

¹¹³ Kelk, above n 14.

surprising. These will be addressed below by referral to the research questions presented at Sections 6.8, 6.9 and 6.10.

6.1 International students

In 2011, international students made up almost a quarter (21.3%) of the total student population on Australian university campuses.¹¹⁴ The results of this study suggest that researchers need to be mindful of the attitudinal and belief dissimilarities between domestic students and international students otherwise their findings may be skewed. There was a very small but noticeable indication that different cultural dynamics were being reflected in the data. This also included a question surrounding ‘social desirability’, that is whether international students were culturally inclined to respond to a prediction of what they thought the researchers wanted to hear.

The study’s findings also have pedagogical implications. Academics wanting to develop curricula that approach the topic of mental illness with sensitivity and respect need to be cognisant of what appear to be significant differences in the mindset of international students, or at least, within the Asian (Malaysian and Singaporean) cultures captured in our study. As 12% of the Australian population in 2011 was Asian-Australian¹¹⁵, anti-stigma researchers and public strategists must also give serious regard to the attitudinal differences of the multicultural Australian population if they want to maximise the opportunities for successful outcomes for future public anti-stigma campaigns.

6.2 No opinions

Although the sample size was a large one, there were a high number of ‘No opinion’ responses. It was foreseen that this might be the case (see the discussion at 5.4). It was also anticipated that the final year respondents would provide more opinions than the first years. It was thought that the four or five years separating the ages of the two groups meant that the final year respondents were more likely to

¹¹⁴ The Commonwealth of Australia, ‘Australian – Educating Globally: Advice from the International Education Advisory Council’ (Advice, International Advisory Council, February 2013) <<https://aei.gov.au/IEAC2/theCouncilsReport/Documents/Australia%20-%20Educating%20Globally%20FINAL%20REPORT.pdf>>.

¹¹⁵ Australian Bureau of Statistics, ‘Guide to Migrant Statistical Sources, 2011 (Edition 2)’ (Reference source, ABS, 29 March 2011) <<http://www.abs.gov.au/AUSSTATS/abs@.nsf/mf/3414.0>>.=

have experienced employment, lived independently and developed diverse social networks. It was presumed that they would be more mature, educated, knowledgeable and aware, and therefore, more opinionated - which they were but overall, only marginally.

In response to the Items that related generally to people who experience mental illness, the first year group had twice the number of Items that recorded 'No opinion' responses greater than 25% than the final year group (12 Items compared to 6 Items). The frequency of the final year's 'No opinion' reporting increased when asked to provide opinions that were specific to legal clients who experienced a mental illness (12 in contrast to 1st years' 14). Final year students are more opinionated when responding to general mental illness statements but are much more circumspect when reporting opinions on legal clients. There was no discernible difference in the 1st years general and specific 'No opinion' reporting. This might suggest that as law students progress through their legal education, they become less willing to express opinions on the law's treatment of people who experience mental illness. The possible reasons for why this may be the case could provide rich ground for future research.

6.3 Socially Desirable Response and 'dangerousness'

What quickly became apparent was that the positive results were significantly more positive than in other, generalised population studies. In Angermeyer's study for example, 30.2% reported that people experiencing a mental illness were just as intelligent as normal people¹¹⁶ compared to our study in which 64% of the respondents reported thinking that they were equally intelligent. Seventy four percent thought that they were discriminated against, in contrast to 47% in Angermeyer's study. That the responses would be more positive was not unexpected as research shows that age and education variables act independently of each other. Lower age and/or higher levels of education have been shown to be associated with more liberal attitudes toward mental illness.¹¹⁷ It is also likely that

¹¹⁶ Matthias Angermeyer and Herbert Matschinger, 'The Stigma of Mental Illness in Germany: A Trend Analysis' (2005) 51 *International Journal of Social Psychiatry* 276.

¹¹⁷ Laurel A Alexander and Bruce G Link, 'The impact of contact on stigmatizing attitudes toward people with mental illness' (2003) 12 *Journal of Mental Health* 271. See also The Scottish Government, 'Well? What Do You Think? (2008): The Fourth National Scottish Survey of Public Attitudes to Mental Wellbeing and Mental Health Problems' (Report, The Scottish Government, 2008) <<http://www.scotland.gov.uk/publications/2009/09/15120147/10>>.

the ‘liberal’ university environment was also a major variable in influencing the students’ responses.¹¹⁸

University liberalism is linked to Socially Desirable Responses (SDR) (see 4.2.3). The tendency in SDR is to be seen in the best possible light¹¹⁹ so respondents provide a positive response when they may actually have a negative attitude. The cause for this can be a consequence of an unconscious deception where they believe what it is they are reporting or it can be the result of a conscious deception whereby the respondent wants to be classed as a person who conforms to socially acceptable values.¹²⁰ Even though the questionnaire is anonymous, respondents may have a genuine need to be ‘counted’ in the socially approved group when the data is dispersed into groupings.

This is what may have occurred with the ‘dangerousness’ issue in this study. One recent study suggested that about a fourth of people are caring and sympathetic toward people who experience mental illness¹²¹ but that even if the majority of the public feels sorry for people and sees them in need of help, ‘a substantial part perceives them as unpredictable and dangerous and reacts with fear’.¹²² A recent Scottish study reported that this ‘substantial part’ was 57%.¹²³ Our results did not correspond with this view despite the fact that a quarter of the respondents considered that they are unpredictable and almost a fifth thought them to be erratic and emotionally unstable. And yet, only 8% reported that they were dangerous; 10% reported feeling scared by them; and 2% thought that they were dangerous and put their lawyer’s safety at risk. One explanation for the low result may be that it is a reflection of the feelings of immortality of youth¹²⁴, a topic worthy of further research if only for its importance as an occupational health and safety issue for

¹¹⁸ Henry, above n 17.

¹¹⁹ Ross, above n 67, 530.

¹²⁰ King, above n 68. Also Ted G Harvey, ‘Comment on Response Biases in Field Studies of Mental Illness’ (1971) 36 *American Sociological Review* 510.

¹²¹ Rosemarie Kobau, Colleen Dilorio, Daniel Chapman and Paolo Delvecchio, ‘Substance Abuse and Mental Health Services Administration/CDC Mental Illness Stigma Panel Members. Attitudes about mental illness and its treatment: validation of a generic scale for public health surveillance of mental illness associated stigma’ (2010) 46 *Community Mental Health Journal* 164.

¹²² Angermeyer and Dietrich, above n 84, 174.

¹²³ The Scottish Government, ‘Well? What Do You Think? (2008): The Fourth National Scottish Survey of Public Attitudes to Mental Wellbeing and Mental Health Problems’ (Report, The Scottish Government, 2008) <<http://www.scotland.gov.uk/publications/2009/09/15120147/10>>.

¹²⁴ Edward Bulwer, Thomas Talfourd and Charles Lamb (eds) *Literary Remains of the Late William Hazlitt: With Notice of His Life* v.2 (Saunders and Otley, 1836). William Hazlitt, On the Feeling of Immortality in Youth.

practicing lawyers. It is more likely that the low reporting of ‘dangerousness’ in response to the statement Items was a result of SDR reporting.

The final page written responses were more elucidating. The fear and avoidance factor analysis showed that the factor was present in the female responses at 43% and in the males at 40%. Also, 22% of respondents reported that people experiencing a mental illness should be forced to take medication if they refused. This result was much lower than Minster’s study which found that 60.9% of lawyers support compulsory medication for schizophrenia, but was slightly higher than Minster’s finding that only 13% of lawyer’s support forced medicating for depression.¹²⁵ The generalised use of the term ‘mentally ill’ should have suggested a result higher than 22% because many respondents would have interpreted ‘mental illness’ as a serious mental illness such as schizophrenia¹²⁶, a disorder inextricably linked to harm to others in the mind of the public.¹²⁷ There were considerable incompatibilities in the quantitative multi-choice responses with the qualitative, free response data sufficient to suggest that the reporting of some issues such as ‘dangerousness’ was not an accurate reflection of respondent attitudes.

6.4 Authoritarianism, benevolence and stereotypes

Previous factor analyses have derived two clusters from the Opinions of Mental Illness questionnaire that reflect prejudicial attitudes toward mental illness.¹²⁸ The first, authoritarianism, is the belief that people who experience mental illness are inferior to normal people, and require coercive handling. Authoritarian values view the person as being incapable of self-care. The second, benevolence, is the kindness shown to the world’s unfortunates who are classed as child like, irresponsible and requiring oversight by a compassionate caretaker. Perceptions of irresponsibility can lead to anger, and both authoritarian and benevolent attitudes lead to decisions to avoid people who experience mental illness.¹²⁹ In this study, benevolence was statistically significant with respondents pitying, and being saddened by people who they classed as helpless and vulnerable, but who were, nonetheless, ‘still human’.

¹²⁵ Judith Minster and Ann Knowles, ‘Exclusion or Concern: Lawyers’ and Community Members’ Perceptions of Legal Coercion, Dangerousness and Mental Illness’ (2006) 13 *Psychiatry, Psychology and Law* 166.

¹²⁶ Alison MacPhail and Simon Verdun-Jones, ‘Mental Illness and the Criminal Justice System (Symposium, Re-Inventing Criminal Justice: The Fifth National Symposium Montreal Quebec, January 2013).

¹²⁷ Minster, above n 125.

¹²⁸ Cohen, above n 31.

¹²⁹ Corrigan, above n 35.

For the most part, the negative results indicate that a large portion of the sample holds prejudicial and stereotypical attitudes toward people who experience mental illness. About a quarter of respondents thought that they should be controlled by laws, and have their own special laws, while a fifth stereotyped them as criminal, irrational, erratic and emotionally unstable. Notably, three quarters reported that they should be protected while nearly 40% thought that they should be treated differently from other people. More than half reported that the legal client needs to be treated differently to other clients while more than a third indicated that they would be unable to properly instruct their lawyer. And although 60% of the final year students (a 9% increase on the 51% response of first years) expressed the attitude that the client should be treated differently to other clients, they had had no practical instruction in how that different treatment might be played out, leaving them susceptible to avoidant, distancing and discriminatory behaviours.

Forty seven percent of first years reported them to be unpredictable, a stereotype largely perpetrated by the media. A 1999 survey by the American Screen Actors' Guild found that 60% of the characters portrayed in prime time as experiencing a mental illness were involved in crime or violence.¹³⁰ Most news accounts portray people with a mental illness as dangerous, or focus their stories on negative characteristics such as unpredictability and unsociability.¹³¹ More than half of the respondents reported seeing a television show in which there was a 'mad psycho killer' within the previous month, while three quarters reported seeing newspaper articles, often or occasionally, at which time they thought the person who committed the crime 'must be insane'. However, as discussed at Section 5.6.1, only 8% reported that they believed that people who experience a mental illness are dangerous.

Without experiential evidence, nearly three quarters of respondents in our study have already stereotyped clients experiencing a mental illness as 'difficult'. Some clinical law students representing clients who have a mental illness have assessed them to be a difficult or demanding client. They also report being appalled by their

¹³⁰ Rich Bayer, Mental illness & violence: A flawed connection, Cecil Daily, April 26, 2013, http://www.cecildaily.com/opinion/columns/article_875109aa-ae0e-11e2-b810-0019bb2963f4.html?TNNoMobile

¹³¹ Otto F Wahl, Amy Wood and Renee Richards, 'Newspaper coverage of mental illness: is it changing?' (2002) 6 Psychiatric Rehabilitation Skills 9.

lack of gratitude which they claim makes it hard for the students to maintain their zeal. 'Time spent on an ungrateful client or a client whom the lawyer or student takes time away from helping someone else, someone about whom a lawyer can feel good.'¹³²

Sometimes, when two sets of emotions working independently of each other conflict, ambivalent prejudice can occur.¹³³ Individualistic attitudes formed on negative stereotypes can collide with positive humanitarian attitudes,¹³⁴ resulting in the reporting of attitudes that are more positive or more negative than they actually are. For example, the law student may see himself or herself as a tolerant, accepting person concerned with the disadvantages experienced by the mentally ill group but believing that 'mentally ill' should seek and engage in treatment. Experiencing a conflict in beliefs, the student can respond more positively to a good interaction than a person who is not ambivalently prejudiced or alternatively, react more negatively to a bad interaction.

The 'difficult' label may be a consequence of ambivalent prejudice, associated with the emotional need of the lawyer to feel appreciated, valued and respected. This transference from the lawyer's expectations and desires to the client's expectations and desires can be seen in our study where, for example, three quarters of respondents reported that the client 'just wants someone to help them'. More than a quarter of respondents also felt comfortable in reporting that clients 'know' that their lawyer acts in their best interests and, they 'trust' their lawyer.

6.5 Gender differences

The study provided minimal evidence to suggest that there are individual differences in the attitudes of females and males to people experiencing a mental illness. Factor analysis was statistically significant in regard to the benevolence factor: females were more benevolent than the males. They felt sorry for the person.

¹³² Marjorie Silver, 'Love, Hate, and Other Emotional Interference in the Lawyer/Client Relationship' (2000) 6 *Clinical Law Review* 259, 300.

¹³³ Mary Kite and Bernard Whitley, 'The Psychology of Prejudice and Discrimination. Wadsworth', Cengage Learning, 2010. See also Tara MacDonald and Mark Zanna, 'Cross-dimension ambivalence toward social groups: Can ambivalence affect intentions to hire feminists?' (1998) 24 *Personality and Social Psychology Bulletin* 427.

¹³⁴ Hisako Matsuo and Kevin McIntyre, 'Ambivalent Prejudice toward Immigrants: The Role of Social Contact and Ethnic Origin' (Paper presented at the annual meeting of the American Sociological Association, Philadelphia PA, 2009) <http://www.allacademic.com/meta/p20113_index.html>.

Although not statistically significant, the percentage comparisons showed that they were also slightly more accepting of the disease model of mental health. Disease is a negative attribute associated with abnormality and avoidance that brings with it external value judgments regarding the person's capacity, vulnerability, and level of responsibility.¹³⁵ Females were also more supportive of forcibly treating the disease. On the other hand, the male responses were slightly more authoritarian. They desired a greater level of social distance. They tended to view the person as different, inferior and dysfunctional, yet conversely, they were less prepared to accept that they were treated differently or unfairly. These findings were consistent with the notion that dominant gender role ideologies shape attitudes toward mental health.¹³⁶

6.6 Free legal representation

An unanticipated finding was that respondents did not, in the main, support free legal representation for people experiencing a mental illness. Only a quarter reported that they agreed with free legal representation while nearly half disagreed. The final year group reported slightly higher than the first years with 5% more in agreement and 7% less in disagreement. These low results appear to run contrary to current pro bono trends around the world. In the United States, universities such as Harvard Law School make it a graduation condition that students contribute at least 40 hours of legal pro bono work.¹³⁷ To be admitted as a legal practitioner in the state of New York, it is mandatory that the applicant has completed 50 hours of voluntary legal work.¹³⁸ Some have described this compulsory plan as 'deeply flawed'.¹³⁹ Its critics view law students as unqualified and inexperienced and therefore, their services are classed as second rate.¹⁴⁰ This is a common assessment amongst practising lawyers in particular that was discussed in Chapter Seven.

¹³⁵ Juha Räikkä, 'The social concept of disease' (1996) 17 *Theoretical Medicine and Bioethics* 353, 356.

¹³⁶ Viren Swami, 'Mental Health Literacy of Depression: Gender Differences and Attitudinal Antecedents in a Representative British Sample' (2012) 7 *PLOS ONE*. See also Sarah Payne, Viren Swami and Debbie L Stanistreet, 'The social construction of gender and its impact on suicidal behaviour' (2008) 5 *Journal of Mens Health Gender* 23.

¹³⁷ Harvard Law School <<http://www.law.harvard.edu/academics/clinical/pro-bono/index.html>>.

¹³⁸ Advisory Committee on New York State Pro Bono Bar Admission Requirements, 'Advisory Committee on New York State Pro Bono Bar Admission Requirements' (Report to the Chief Judge of the State of New York and the Presiding Justices of the Four Appellate Division Departments, September 2012) <<http://files.equaljusticeworks.org/Pro-Bono-Req-Committee-Report.pdf>>.

¹³⁹ Ben Trachtenberg, 'Rethinking Pro Bono By Ben Trachtenberg', *New York Times* (online), 13 May 2012 <<http://www.nytimes.com/2012/05/14/opinion/a-better-pro-bono-plan.html>>.

¹⁴⁰ Ibid.

A 2001 survey of Australian law schools found that very few Australian law schools had a considered or coherent policy in relation to developing a pro bono ethos in law students¹⁴¹, however, by 2009, retired High Court judge Michael Kirby was arguing that Australia's 31 law faculties should make it mandatory for students to gain work experience on 'pro bono' cases.¹⁴² In March 2013, Attorney-General Mark Dreyfus admitted to feeling very strongly that compulsory pro bono requirements for students to be admitted as lawyers 'would enhance the sense of social justice in aspiring lawyers... help foster a pro bono culture, while also providing very valuable and practical legal experience'.¹⁴³ However, the focus in Australia has clearly remained on voluntariness with Australian universities encouraging law students to 'recognise the value of pro bono work, and to commit to undertaking pro bono work both while they are students and in their professional careers'.¹⁴⁴

Every year in most Australian jurisdictions, thousands of citizens with a mental illness are brought before administrative courts where, without the benefit of legal representation, decisions are made that will deprive them of their basic rights, including their right to liberty. While there is clearly a global push by many politicians, academics, social justice advocates and committed law students for law students to take on the role of 'free lawyer' to the disadvantaged, this study suggests that the majority of respondents report holding the view that disadvantaged people who experience mental illness should not have an entitlement to a free legal service. The fact that 93% of respondents reported that people with a mental illness have rights that 'must' be protected seems incongruous with this view. Whether the students' reported position is relative to all disadvantaged groups or is a sanist manifestation is a subject for further research.

¹⁴¹ Australian Law Reform Commission, 'National Pro Bono Task Force: Recommended Action Plan for National Co-Ordination and Development of Pro Bono Legal Services' (Report, ALRC, 14 June 2001).

¹⁴² Michael Kirby, 'The Need for Clinical Experience in Australian Law Schools' (Paper presented at the International Association of Law Schools Conference, Canberra Australia, 26 May 2009) <http://www.michaelkirby.com.au/images/stories/speeches/2000s/2009+/2357.International_Association_Of_Law_Schools_-_26_May_2009..pdf>

¹⁴³ Michael Legg and John Corker, 'Take care in pushing student pro bono', *The Australian* (online) 26 April 2013 <<http://www.theaustralian.com.au/business/legal-affairs/take-care-in-pushing-student-pro-bono/story-e6frg97x-1226629553945>>.

¹⁴⁴ TC Beirne School of Law, *Pro Bono Roster* (2010) The University of Queensland <<http://www.law.uq.edu.au/pro-bono-roster>>.

6.7 The influence of personal experience of a mental illness on responses

The responses of respondents who identified as having had a mental illness were significantly less authoritarian, less benevolent and less stereotypical than the non-mental illness group although the study was limited by the small sample of final year respondents (14). There were indicators of an emotional reaction¹⁴⁵ from the subgroup responses. Nearly all of the respondents reported that people who experience a mental illness also experience stigma and discrimination. 'The stigma associated with mental illness has to be experienced to be believed'.¹⁴⁶ An example was the group responses to the stigmatising stereotype that a person experiencing a mental illness could not properly instruct their lawyer. Almost half of the non-mental illness group agreed with the stereotype compared to 0% of the mental illness group. Seventy one percent of the mental illness group disagreed with the stereotype but only 28.5% of the non- mental illness group disagreed.

It was interesting that the mental illness group reported using more pejorative language. This might be a result of 'mad pride' and the reclamation of 'mad speak' along the lines of 'gay pride' and reclaiming 'queer' language which was discussed in Chapter Four. Using language in this way can simultaneously build up and tear down boundaries of identity. Possibly, the results are also a reflection of the obligation that people who do not experience a mental illness feel to be politically correct in their speech, or at least, to report that they are politically correct in their speech. However, the high numbers of both groups reporting the use of offensive, dehumanising and disrespectful language supports the claims of mental health advocates that mental illness prejudice and stigma still operate at all levels¹⁴⁷ including, amongst Australia's future lawyers.

¹⁴⁵ Bruce Q Link, Lawrence H Yang, Jo C Phelan and Pamela Y Collins, 'Measuring Mental Illness Stigma' (2004) 30 *Schizophrenia Bulletin* 511.

¹⁴⁶ The Mental Health Legal Centre Inc., '20/20 Hindsight: A History of the Mental Health Legal Centre Inc.' (Report, Mental health Legal Centre Inc., November 2006) 5
<http://www.communitylaw.org.au/clc_mentalhealth/cb_pages/images/20_20_Hingsight_Final.pdf>.

¹⁴⁷ Mark Metherell, 'Mental health failure tied to prejudice: McGorry' *The Age* (online), 23 June 2010
<<http://www.theage.com.au/national/mental-health-failure-tied-to-prejudice-mcgorry-20100622-yvuf.html>>.

6.8 Research question 1 – Are law student attitudes sanist?

As discussed in Chapter Five, prejudicial beliefs and discriminatory behaviours are components of stigma and sanism. Stigma encompasses the sanist framework of prejudicial and stereotypical beliefs, attitudes and practices.¹⁴⁸ Stereotyping and prejudice against different groups does not always take the same form but it does, usually, involve members of the out-group being pitied, marginalised, and patronised. The results of this study indicate that the ‘mentally ill’ as a group is largely pitied by law students who perceive its members to be incapable of proper functioning and requiring protection and control. Eighty one percent of final year and 71% of first year respondents reported that people who experience a mental illness need to be protected. Overall, the Group 1 responses appear to suggest that there is a high level of sanist attitudes amongst law students, particularly benevolent prejudice which is considered to be as detrimental to an out-group as the hostile prejudices.¹⁴⁹

6.9 Research question 2 – Are final year law student attitudes more sanist than the attitudes of first year law students?

It had been anticipated that the final year group would exhibit more sanist attitudes than the first year group. Guimond’s social dominance orientation research, discussed above at Section 2.0, showed that law students were more prejudiced than students studying other academic disciplines. He suggested that law students would become more prejudiced as they continued in their legal education. It was also assumed therefore that as the final year respondents had 4/5 years of university education compared to the few weeks experienced by the first year respondents, their responses would reflect the greater liberal/tolerant/benevolent attitudes reported in the findings of previous research. There was a concern that the ‘liberalist’ stereotypical expectation attached to ‘university students’ might increase the respondent’s susceptibility to socially desired reporting which could significantly influence the results.

¹⁴⁸ Jennifer M Poole *et al.*, ‘Sanism, ‘Mental Health’, and Social Work/Education: A Review and Call to Action’ (2012) 1 *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice* 20.

¹⁴⁹ Dale Miller and Benoit Monin, ‘Moral credentials and the expression of prejudice’ (2001) 81 *Journal of Personality and Social Psychology* 33.

Additionally, it was thought that 4/5 years of legal education in which only extreme cases of mental incapacity and functional incapability were studied might result in more authoritarian and benevolent responses from the final year students. This appeared to be somewhat the case. The only statistically significant difference observed indicated that twice as many final years than 1st years reported that people who experience mental illness need their own special laws. On the other hand, more than double the number of first years compared to final years thought that people with a mental illness were unpredictable and almost double thought that they were erratic and unstable. This suggests that reliance on stereotypes decreases as students continue in their studies.

The slight increase in benevolence and authoritarianism in the final year group was matched by a slight decrease in its social awareness. For example, almost half of the final year respondents disagreed with the notion that legal clients who experience a mental illness might be labeled or judged unfairly. There was a faint, but noticeable trend of final year respondents reporting a more positive view of the law's role and practices in relation to mental illness. This view may underlie the respondents' conviction that legal clients with mental illness are not labelled and unfairly treated by the legal system. It may also suggest a humanitarian justification for the respondent's career choice: a career in which lawyers help disadvantaged people who 'just want someone to help them'.

Although there was little statistically discernible difference in the levels of sanism demonstrated by both groups, the final year group appeared to be slightly more benevolent and authoritarian in their attitudes, and less informed by stereotypes than was the first year group. Overall, both groups were sanist in their attitudes.

6.10 Research question 3 – Are Mental Health Tribunal Representation Scheme (MHTRS) participants less sanist?

The third research question examined whether the reported views of final year students who identified as having participated in the MHTRS were less sanist than the group that had not participated in the scheme. The results were limited by the fact that only five respondents reported having had contact with a client. As discussed in Chapters Three and Seven, contact, in combination with specialist

education is an important component for positive attitudinal change. It was clear from the responses that the participant group was more opinionated. This may have been the result of the respondent's confidence in having gained accurate knowledge of the topic from their MHTRS training.

The responses were inconsistent. At some Items, the participant group showed more benevolent or authoritarian attitudes while at other Items, it showed much less. The participant group also indicated a higher level of fear than the non-participant group. A possible reason for the mixed results might be that the participant group respondents had personal contact with clients who had a serious mental illness. These clients were also so acutely unwell that they were detained involuntarily in a locked mental health hospital setting. Research has shown that acquiring knowledge of the symptoms associated with the acute phase of schizophrenia increases negative reactions to people who have schizophrenia.¹⁵⁰ Following this logic, contact with people manifesting the behaviours of acute phases of serious mental illnesses may increase participant's negative reactions. Also, the environments in which respondents worked with their clients are not the stereotypical asylum 'snake pits' but comfortable, well appointed, hospital visitors' room. Hearings before the Mental Health Tribunal were held in well appointed meeting rooms where informal and non-adversarial processes were undertaken by parties, all of whom indicated that they wanted only that which was in the best interests of the client.

Respondents may have reported attitudes particular to a group of people having a specific type of mental illness. Their attitudes had been formed based on actual experiences with mental health law, both positive and negative, and working with clients who were acutely mentally unwell, and of whom, some, were indeed dangerous. While the majority of the participant group had not had contact with a client, they had undergone specialist training relevant to working with acutely unwell clients including mental health literacy topics and occupational health and safety strategies (see Chapter Seven). As participants, they also attended regular

¹⁵⁰ David L Penn, Kim Guynan, Tamara Daily, William D Spaulding, Calvin P Garbin and Mary Sullivan, 'Dispelling the stigma of schizophrenia: what sort of information is best?' (1994) 20 *Schizophrenia Bulletin* 567.

mentoring events and had ongoing relationships with their peers who had had contact experience.

The most unexpected result, however, was that a higher percentage of participant group members reported that people experiencing mental illness should not have access to a free lawyer. The MHTRS is a social justice initiative that provides a free legal service to a vulnerable and disadvantaged group who, prior to the inception of the scheme 11 years ago, appeared before the tribunal without representation. It was anticipated that the volunteer law students would, through their participation and commitment to the scheme, develop a strong pro-bono ethic. This does not seem to have occurred. The influence of participation in therapeutic jurisprudence type clinical education programs, similar to the MHTRS, is clearly an area requiring further research, using larger samples than was used in this study.

7. CONCLUSION

The purpose of Chapter Eight was twofold. First, it offered an empirical test of the attitudes of law students regarding people who experience mental illness to determine whether, as Perlin suggests, law student attitudes are sanist¹⁵¹ and whether they become more sanist as they progress their legal education. The decision was made to remove the international cohort from the study because the intention was to explore the phenomenon of sanism in the Australian legal system and cultural differences appeared to be impacting on the data. However, it is important to recognise and combat sanism in every culture so it is hoped that future researchers will examine the impact of sanism on Asian the legal systems. Secondly, Chapter Eight tried to quantify the impact that participation in the Mental Health Tribunal Representation Scheme (MHTRS) has on influencing the attitudes of its participants.

The chapter builds on the discussion contained in the preceding chapter in an important way. Chapter Seven discussed the MHTRS. It pointed to theory that the MHTRS could work to alter student attitudes and reduce sanism in the legal system. This was argued on that basis that the MHTRS was built on principles of therapeutic jurisprudence; delivered a short, appropriate mental health education

¹⁵¹ Perlin, above n 1.

program that was developed specifically for law students; and provided student participants with the opportunity for professional face to face contact between themselves and their mental health clients. Consequently, the second contribution of Chapter Eight is that it examines the influence that participation in the MHTRS has on law students' attitudes.

A weakness of the study was the high level of 'No opinion' responses, particularly from the final year respondents exiting legal education. This presented the author with the concern that soon so many new, un-opinionated lawyers would enter the sanist and pretextual legal system that Perlin describes, a description that Chapter Six in this thesis gave support to in the limited area of family law parenting decisions. These new legal professionals would be susceptible to the perpetuating influence of sanist legal actors, and the embedded sanist and pretextual practices that stereotype and label, and prejudice and discriminate against legal parties who have a mental illness.

The responses suggest that, overall; the students reported more positive attitudes than were evident in other, generalised population studies. Due to age and education variables, this was anticipated; however, the degree of positivity when examined in conjunction with the apparent factor inconsistencies imply that there may have been a significant scale of socially desirable reporting, a process that weakens the predictive validity of results obtained in socially sensitive domains such as prejudice and stereotyping. Over recent decades, the concern attached to appearing prejudiced has become a real source of debilitating anxiety, 'akin to the stereotype threat experienced by the stigmatised'.¹⁵² As discussed in Chapter Four, when negative stereotypes persist but there are ramifications for expressing outward hostilities toward negatively stereotyped groups, prejudice commonly manifests itself in benevolent behaviors.¹⁵³ In this situation, it is safe to suggest that the results show that that a large number of respondent law students are sanist, and that this number might be even greater than the results indicate.

¹⁵² Jennifer Crocker, Brenda Major and Claude Steele, 'Social stigma' in Daniel T Gilbert, Susan T Fiske and Gardner Lindzey (eds), *The handbook of social psychology* (McGraw-Hill, 1998) 540.

¹⁵³ Peter Glick and Susan Fiske, 'An ambivalent alliance: Hostile and benevolent sexism as complementary justifications for gender inequality' (2001) *56 American Psychologist* 109.

Overall, the opinionated students entering and exiting the University of Tasmania law school reported strongly benevolent attitudes although both groups had a considerable authoritarian viewpoint. There was a slight trend showing that the final years had developed more authoritarian attitudes. Benevolence was the dominant feature of the female respondent groups while males were more authoritarian in their reported views. Considering that females make up over half of all law graduates of Australian universities, it is not improbable to think that future government policies, legislation and legal decision-making, procedures and practices will reflect a benevolent approach to mental health in Australia.

Many of the students had clearly prejudged their future clients. Prior to leaving university and before any actual professional contact with clients with a mental illness had occurred; the students had negatively stereotyped and labeled clients with mental illness as ‘difficult’. They had pessimistically presumed their clients capabilities and assumed, probably erroneously, what would be their client’s feelings and thoughts.

While almost all of the respondents reported holding the benevolent belief that people, and their rights, require protecting, few supported their access to free representation which did not appear to support a strong *pro bono* ethic amongst the students. This inconsistency raises the question of exactly how their rights can be protected, and by whom, if not through access to a free legal service. Students who identified as having experienced a mental illness were more aware of the issues of stereotypes, stigma and discrimination, and more cognisant as to the functioning capabilities of a person experiencing a mental illness. In particular, they were more supportive of the need for access to a free legal service than the other respondents, and surprisingly, than students who had participated in the MHTRS.

The study confirmed the high level of often and occasional use of pejorative and disparaging language amongst law students. This is not surprising because the casual use of language stigmatising mental illness is generally, exceedingly common. The problem is that in a world in which people who experience mental illness are still struggling for increased understanding and acceptance, the continuation of this language, as discussed in Chapter Four, is considered by mental health advocates to be largely responsible for the continual reinforcement of

negative attitudes and discriminatory behaviours. Students who experience a mental illness might better protest rather than claim its use. Language is an important topic in the necessary process for attitudinal change and requires further research.

Finally, there was insufficient data to reach a concrete finding as to whether participation in the Mental Health Tribunal Representation Scheme had a positive influence on the attitudes of students. The sample was small, and less than half had had contact with a client with a mental illness. The results were also inconsistent. Some Items indicated that the group was more sanist in its reporting, and at others, it was less. Possible reasons have been offered for why this was so, however, it is clearly an area of important discussion requiring further research as more mental health representation programs commence operations.

8. MAJOR FINDINGS:

1. This study found that the law students reported significantly more positive attitudes toward people who experience mental illness than respondents in other, general population studies.
2. The law students predominately reported attitudes that were strongly indicative of benevolent prejudice.
3. The law students also reported attitudes that indicated a high level of authoritarian prejudice.
4. The overseas law students reported significantly higher levels of prejudiced attitudes than the domestic law students.
5. The reported attitudes of female law students were more benevolent compared to male law students whose attitudes were more authoritarian.
6. The reported attitudes of law students indicated a slight trend that attitudes become more authoritarian as students progress through law school.
7. A very high percentage of law students indicated that they had negatively stereotyped and labelled clients who experience a mental illness.
8. The majority of law students did not support the access of a person who experiences mental illness to free legal representation
9. Law students who identified as having experienced a mental illness were more informed; more aware of the barriers; and more supportive of the need for free legal service access.

10. A high percentage of law students reported using offensive, insulting and disrespectful language often, including students who identified as having a personal experience of mental illness.
11. The results comparing the attitudes of law students who had participated in the MHTRS with respondents who had not were inconsistent, and inconclusive, because of the small sample size, and the different levels of involvement that participants' had had in the program.

BIBLIOGRAPHY

Articles

Alexander, Laurel A and Bruce G Link, 'The impact of contact on stigmatizing attitudes toward people with mental illness' (2003) 12 *Journal of Mental Health* 271.

Angermeyer, Matthias C and Herbert Matschinger, 'Social distance towards the mentally ill: results of representative surveys in the Federal Republic of Germany (1997) 27 *Psychological medicine* 131.

Angermeyer, Matthias C and Herbert Matschinger, 'The Stigma of Mental Illness in Germany: A Trend Analysis' (2005) 51 *International Journal of Social Psychiatry* 276.

Angermeyer, Matthias C and Herbert Matschinger, 'Violent attacks on public figures by persons suffering from psychiatric disorders. Their effect on the social distance towards the mentally ill' (1995) 245 *European Archives of Psychiatry and Clinical Neuroscience* 159.

Angermeyer, Matthias C Herbert Matschinger and Patrick W. Corrigan, 'Familiarity with mental illness and social distance from people with schizophrenia and major depression: testing a model using data from a representative population survey' (2004) 69 *Schizophrenia research* 175.

Angermeyer, Matthias C, Anita Holzinger and Herbert Matschinger, 'Emotional reactions to people with mental illness' (2010) 19 *Epidemiologia e Psichiatria Sociale* 26.

Angermeyer, Matthias C, Herbert Matschinger and Georg Schomerus, 'Attitudes towards psychiatric treatment and people with mental illness: changes over two decades.' (2013) 203 *The British Journal of Psychiatry* 146.

Arkar, Haluk and Doğan Eker, 'Effects of psychiatric labels on attitudes toward mental illness in a Turkish sample' (1994) 40 *International Journal of Social Psychiatry* 205.

Arnett, Jeffrey Jensen, 'Emerging adulthood: A theory of development from the late teens through the twenties' (2000) 55 *American Psychologist* 469.

Bender, Timothy A, 'Time of participation effect and grade-orientation' (2007) 43 *Personality and Individual Differences* 1175.

Boyd, Jennifer E, Emerald P Katz, Bruce G Link, and Jo C Phelan, 'The relationship of multiple aspects of stigma and personal contact with someone hospitalized for mental illness, in a nationally representative sample' (2010) 45 *Social psychiatry and psychiatric epidemiology* 1063.

Brohan, Elaine, Claire Henderson, Kirsty Little and Graham Thornicroft, 'Employees with mental health problems: survey of UK employers' knowledge, attitudes and workplace practices' (2010) 19 *Epidemiol Psichiatria Sociale* 326.

Butler, Corey J, 'Authoritarianism and fear responses to pictures: The role of social differences (2013) 48 *International Journal of Psychology* 18.

Cohen, Jacob and E L Struening, 'Opinions about mental illness in the personnel of two large mental hospitals' (1962) 64 *Journal of Abnormal and Social Psychology* 349.

- Corrigan, Patrick W and Amy C Watson, 'Understanding the impact of stigma on people with mental illness' (2002) 1 *World Psychiatry* 16.
- Corrigan, Patrick W *et al.*, 'Prejudice, Social Distance, and Familiarity with Mental Illness' (2001) 27 *Schizophrenia Bulletin* 219.
- Corrigan, Patrick W, Amy Kerr and Lissa Knudsen, 'The stigma of mental illness: Explanatory models and methods for change' (2005) 11 *Applied and Preventive Psychology* 179.
- Corrigan, Patrick, 'How Stigma Interferes With Mental Health Care' (2004) 59 *American Psychologist* 614.
- Corrigan, Patrick, Fred E. Markowitz, Amy Watson, David Rowan, and Mary Ann Kubiak. 'An attribution model of public discrimination towards persons with mental illness' (2003) 44 *Journal of Health and Social Behavior* 162.
- Couch, Arthur, Kenneth Keniston, 'Yeasayers and naysayers: Agreeing response set as a personality variable' (1960) 60 *Journal of Abnormal and Social Psychology* 151.
- Crisp, Arthur *et al.*, 'Stigmatisation of people with mental illnesses: a follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists' (2005) 4 *World Psychiatry* 106.
- Dammeyer, Matthew M and Narina Nunez, 'Anxiety and Depression among Law Students: Current Knowledge and Future Directions' (1999) 23 *Law and Human Behavior* 55.
- Dasgupta, Nilanjana and Matthew Hunsinger, 'The Opposite of a Great Truth Is Also True: When Do Student Samples Help Versus Hurt the Scientific Study of Prejudice?' (2008) 19 *Psychological Inquiry* 90.
- Garland, Ron, 'The Mid-Point on a Rating Scale: Is it Desirable?' (1991) 2 *Marketing Bulletin* 66.
- Gilbert, Daniel T, 'How Mental Systems Believe' (1991) 46 *American Psychologist* 107.
- Gilbert, Doris C and Daniel J Levinson, 'Ideology, Personality and Institutional Policy in the Mental Hospital' (1956) 53 *Journal of Abnormal Social Psychology* 263.
- Glăveanu, Vlad, 'Stereotypes Revised – Theoretical Models, Taxonomy and the Role of Stereotypes' (2007) 3 *Europe's Journal of Psychology* (online)
<<http://ejop.psychopen.eu/article/view/409/308>>.
- Glick, Peter and Susan Fiske, 'An ambivalent alliance: Hostile and benevolent sexism as complementary justifications for gender inequality' (2001) 56 *American Psychologist* 109.
- Gordon, Michael E, L Allen Slade and Neal Schmitt, 'The "Science of the Sophomore" Revisited: from Conjecture to Empiricism' (1986) 11 *Academy of Management Review* 191.
- Granello, Darcy Haag and Paul F Granello, 'Defining Mental Illness: The Relationship Between College Students' Beliefs About the Definition of Mental Illness and Tolerance' (2000) 3 *Journal of College Counseling* 100.

Guimond, Serge *et al.*, 'Does Social Dominance Generate Prejudice? Integrating Individual and Contextual Determinants of Intergroup Cognitions' (2003) 84 *Journal of Personality and Social Psychology* 697.

Gupta, Ashum and Pushpa Bonnell, 'Opinions about mental illness among college students' (1993) 9 *Journal of Personality and Clinical Studies* 63.

Harvey, Ted G, 'Comment on Response Biases in Field Studies of Mental Illness' (1971) 36 *American Sociological Review* 510.

Henrich, Joseph, Steven J. Heine and Ara Norenzayan, 'The weirdest people in the world?' (2010) 33 *Behavioral and Brain Sciences*, 61.

Henry, P J, 'College Sophomores in the Laboratory Redux: Influences of a Narrow Data Base on Social Psychology's View of the Nature of Prejudice' (2008) 19 *Psychological Inquiry: An International Journal for the Advancement of Psychological Theory* 49.

Holmes, Paul E *et al.*, 'Changing attitudes about schizophrenia' (1999) 25 *Schizophrenia Bulletin* 447.

Hugo, Charmaine J *et al.*, 'Community attitudes toward and knowledge of mental illness in South Africa' (2003) 38 *Social Psychiatry Psychiatric Epidemiology* 715.

Jeffrey Jensen Arnett, 'The neglected 95%: Why American psychology needs to become less American' (2008) 63 *American Psychologist* 7.

Johns, Robert A, 'One size doesn't fit all: Selecting response scales for BES attitude Items' (2005) 15 *Journal of Elections, Public Opinion and Parties* 237.

Johnson, Doyle P, 'Religious Commitment, Social Distance, and Authoritarianism' (1977) 18 *Review of Religious Research* 99.

Johnson, Timothy P, Michael Fendrich and Mary Ellen Mackesy-Amity, 'An evaluation of the validity of the Crowne-Marlowe need for approval scale' (2012) 46 *Quality & Quantity* 1883.

Kessler, Ronald C *et al.*, 'Age of onset mental disorders: a review of recent literature' (2007) 20 *Current Opinion in Psychiatry* 359.

King, Maryon F and Gordon C Bruner, 'Social desirability bias: a neglected aspect of validity testing' (2000) 17 *Psychology and Marketing* 79.

Knowles, Eric S and Christopher A Condon, 'Why People Say 'Yes': A Dual-Process Theory of Acquiescence' (1999) 77 *Journal of Personality and Social Psychology* 379.

Knowles, Eric S and Nathan T Kobi, 'Acquiescent responding in self-reports: Cognitive style or social concern?' (1997) 31 *Journal of Research in Personality* 293.

Kobau, Rosemarie, Colleen DiIorio, Daniel Chapman and Paolo Delvecchio, 'Substance Abuse and Mental Health Services Administration/CDC Mental Illness Stigma Panel Members. Attitudes about mental illness and its treatment: validation of a generic scale for public health surveillance of mental illness associated stigma' (2010) 46 *Community Mental Health Journal* 164.

Krieger, Lawrence S, 'Institutional Denial about the Dark Side of Law School, and Fresh Empirical Guidance for Constructively Breaking the Silence' (2002) 52 *Journal of Legal Education* 112.

Kulas, John T, Alicia A Stachowski and Brad A Haynes, 'Middle Response Functioning in Likert-responses to Personality Items' (2008) 22 *Journal of Business Psychology* 251.

Likert, Rensis, 'A technique for the measurement of attitudes' (1932) 22 *Archives of Psychology* 55.

Link, Bruce G *et al.*, 'Public conceptions of mental illness: labels, causes, dangerousness and social distance' (1999) 89 *American Journal of Public Health* 1328.

Link, Bruce G, Jo C. Phelan, Michaeline Bresnahan, Ann Stueve, and Bernice A Pescosolido, 'Public conceptions of mental illness: labels, causes, dangerousness, and social distance' (1999) 89 *American Journal of Public Health* 1328.

Link, Bruce Q, Lawrence H Yang, Jo C Phelan and Pamela Y Collins, 'Measuring Mental Illness Stigma' (2004) 30 *Schizophrenia Bulletin* 511.

Lyons, Mike and Robyn Hayes, 'Student Perceptions of Persons with Psychiatric and Other Disorders' (1993) 47 *The American Journal of Occupational Therapy* 541.

MacDonald, Tara and Mark Zanna, 'Cross-dimension ambivalence toward social groups: Can ambivalence affect intentions to hire feminists?' (1998) 24 *Personality and Social Psychology Bulletin* 427.

Matthias C Angermeyer and Sandra Dietrich, 'Public beliefs about and attitudes towards people with mental illness: a review of population studies' (2005) 113 *Acta Psychiatrica Scandinavica* 163.

McKinney, Ruth Ann, 'Depression and Anxiety in Law Students: Are We Part of the Problem and Can We Be Part of the Solution' (2002) 8 *The Journal of the Legal Writing Institute* 229.

Miller, Dale and Benoit Monin, 'Moral credentials and the expression of prejudice' (2001) 81 *Journal of Personality and Social Psychology* 33.

Minster, Judith and Ann Knowles, 'Exclusion or Concern: Lawyers' and Community Members' Perceptions of Legal Coercion, Dangerousness and Mental Illness' (2006) 13 *Psychiatry, Psychology and Law* 166.

Ng, Petrus and Kai-Fong Chan, 'Attitudes towards people with mental illness. Effects of a training program for secondary school students' (2002) 14 *International Journal of Adolescent Medical Health* 215.

Payne, Sarah, Viren Swami and Debbie L Stanistreet, 'The social construction of gender and its impact on suicidal behaviour' (2008) 5 *Journal of Mens Health Gender* 23.

Penn, David L, Kim Guynan, Tamara Daily, William D Spaulding, Calvin P Garbin and Mary Sullivan, 'Dispelling the stigma of schizophrenia: what sort of information is best?' (1994) 20 *Schizophrenia Bulletin* 567.

Perlin, Michael L, 'You Have Discussed Lepers and Crooks: Sanism in Clinical Teaching' (2003) 9 *Clinical Law Review* 683.

Pescosolido, Bernice A *et al.*, “‘A Disease Like Any Other’”? A Decade of Change in Public Reactions to Schizophrenia, Depression, and Alcohol Dependence’ (2010) 167 *American Journal of Psychiatry* 1321.

Phelan, Jo C and Bruce G Link, ‘Fear of People with Mental Illnesses: The Role of Personal and Impersonal Contact and Exposure to Threat or Harm’ (2004) 45 *Journal of Health and Social Behavior* 68.

Phillips, Derek L and Kevin J Clancy, ‘Response Biases in Field Studies of Mental Illness’ (1970) 35 *American Sociological Review* 503.

Poole, Jennifer M *et al.*, ‘Sanism, ‘Mental Health’, and Social Work/Education: A Review and Call to Action’ (2012) 1 *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice* 20.

Raaijmakers, Quinten A W *et al.*, ‘Adolescents’ Midpoint Responses on Likert-Type Scale Item: Neutral or Missing Values?’ (2000) 12 *International Journal of Public Opinion Research* 208.

Räikkä, Juha, ‘The social concept of disease’ (1996) 17 *Theoretical Medicine and Bioethics* 353.

Ramsey, Glenn V and Melita Seipp, ‘Attitudes and opinions concerning mental illness’ (1948) 22 *Psychiatric Quarterly* 428.

Ramsey, Glenn V and Seipp, Melita, ‘Public opinions and information concerning mental health’ (1948) 4 *Journal of Clinical Psychology* 397.

Ritsuko, Kakuma *et al.*, ‘Mental Health Stigma: What is being done to raise awareness and reduce stigma in South Africa?’ (2010) 13 *African Journal of Psychiatry* 116.

Rose, Diana Graham Thornicroft, Vanessa Pinfold, and Aliya Kassam, ‘250 labels used to stigmatise people with mental illness’ (2007) 7 *BMC Health Services Research* 97.

Ross, Catherine E and John Mirowsky, ‘The worst place and the best face’ (1983) 62 *Social Forces* 529.

Sears, David O, ‘College Sophomores in the Laboratory: Influences of a Narrow Data Base on Social Psychology’s View of Human Nature’ (1986) 51 *Journal of Personality and Social Psychology* 515.

Shanfield, Stephen B and G Andrew H Benjamin, ‘Psychiatric Distress in Law Students’ (1985) 35 *Journal of Legal Education* 65.

Shrivastava, Amresh, Megan Johnston and Yves Bureau, ‘Stigma of Mental Illness-1: Clinical reflections’ (2012) 10 *Mens Sana Monographs* 70.

Silver, Marjorie, ‘Love, Hate, and Other Emotional Interference in the Lawyer/Client Relationship’ (2000) 6 *Clinical Law Review* 259.

Smith, Allison L and Craig S Cashwell, ‘Social Distance and Mental Illness: Attitudes Among Mental Health and Non-Mental Health Professionals and Trainees’ (2011) 1 *The Professional Counselor* 13.

Stuart, Heather, ‘Violence and mental illness: an overview’ (2003) 2 *World Psychiatry* 121.

Teachman, Bethany A, Joel G Wilson and Irina Komarovskaya, 'Implicit and Explicit Stigma of Mental Illness in Diagnosed and Healthy Samples' (2006) 25 *Journal of Social and Clinical Psychology* 75.

van't Veer, Job T, Herro F Kraan, Stans HC Drosseart, and Jacqueline Modde, 'Determinants that shape public attitudes towards the mentally ill' (2006) 41 *Social psychiatry and psychiatric epidemiology* 310.

Wahl, Otto F, Amy Wood and Renee Richards, 'Newspaper coverage of mental illness: is it changing?' (2002) 6 *Psychiatric Rehabilitation Skills* 9.

Watson, Amy C, 'Changing Middle Schoolers' Attitudes About Mental Illness Through Education' (2004) 30 *Schizophrenia Bulletin* 563.

Watson, Amy C, Patrick W Corrigan and Beth Angell, 'What motivates public support for legally mandated mental health treatment?.' (2005) 29 *Social Work Research* 87.

Wu, Chien-Ho, 'An empirical study on the transformation of Likert-scale data to numerical scores' (2007) 1 *Applied Mathematical Sciences* 2851.

Yamaguchi, Sosei , Yoshio Mino and Shahir Uddin, 'Strategies and future attempts to reduce stigmatisation and increase awareness of mental health problems among young people: a narrative review of educational interventions', (2011) 65 *Psychiatry and clinical neurosciences* 405.

B. Books

Brown, Rupert, *Prejudice: Its Social Psychology* (John Wiley & Sons, 2010).

Bulwer, Edward, Thomas Talfourd and Charles Lamb (eds) *Literary Remains of the Late William Hazlitt: With Notice of His Life* v.2 (Saunders and Otley, 1836). William Hazlitt, On the Feeling of Immortality in Youth.

Crocker, Jennifer, Brenda Major and Claude Steele, 'Social stigma' in Daniel T Gilbert, Susan T Fiske and Gardner Lindzey (eds), *The handbook of social psychology* (McGraw-Hill, 1998) 540.

Druckman, James N and Cindy D Kim, 'Students as Experimental Participants: A Defense of the "Narrow Data Base"' in James N Druckman *et al.* (eds), *Cambridge Handbook of Experimental Political Science*, (Cambridge University Press, 2011).

Freeman, Daniel and Jason Freeman, *The Stressed Sex: Uncovering the Truth About Men, Women, and Mental Health* (Oxford University Press, 2013).

Kite, Mary and Bernard Whitley, 'The Psychology of Prejudice and Discrimination. Wadsworth', Cengage Learning, 2010.

Maranell, Gary M, *Scaling: A Sourcebook for Behavioral Scientists* (Transaction Publishers, 2009).

Rosenthal, Robert and Ralph L Rosnow, *Essentials of behavioral research: Methods and data analysis* (McGraw-Hill, 1991).

Thornicroft, Graham and Aliya Kassam, 'Public attitudes, stigma and discrimination against people with mental illness' in Craig Morgan, Kwame McKenzie and Paul Fearon (eds), *Society and Psychosis* (Cambridge University Press, 2008).

C. Grey Literature -Research Papers, Reports, Submissions, Letters, Memos etc

Advisory Committee on New York State Pro Bono Bar Admission Requirements, 'Advisory Committee on New York State Pro Bono Bar Admission Requirements' (Report to the Chief Judge of the State of New York and the Presiding Justices of the Four Appellate Division Departments, September 2012) <<http://files.equaljusticeworks.org/Pro-Bono-Req-Committee-Report.pdf>>.

Attitudes to Mental Illness - 2011 (Survey report, National Health Service, U.K., 2011) <http://www.hscic.gov.uk/catalogue/PUB00292>

Australian Bureau of Statistics, 'Guide to Migrant Statistical Sources, 2011 (Edition 2)' (Reference source, ABS, 29 March 2011) <<http://www.abs.gov.au/AUSSTATS/abs@.nsf/mf/3414.0>>.

Australian Law Reform Commission, 'National Pro Bono Task Force: Recommended Action Plan for National Co-Ordination and Development of Pro Bono Legal Services' (Report, ALRC, 14 June 2001).

Canadian Medical Association, '8th Annual National Report Card on Health Care' (Report, Ipsos Reid Public Affairs, 18 August 2008) <http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/Annual_Meeting/2008/GC_Bulletin/National_Report_Card_EN.pdf>.

Chimi, Carl J and David L Russell, 'The Likert Scale: A Proposal for Improvement Using Quasi-Continuous Variables' (2009) *Proceedings Information Systems Education Conference*, 4333.

Gender and women's mental health, Gender disparities and mental health: The Facts, World Health Organization, Mental Health (Fact Sheet, WHO, 2013) http://www.who.int/mental_health/prevention/genderwomen/en/.

Green, Kathy E, Gary Allen and Tony CM Lam, 'Is Neutral on a Likert Scale the Same As "Don't Know" For Informed and Uniformed Respondents? Effects of Serial Position and Labelling on Selection of Response Options, Paper presented at the National Council on Measurement in Education, Denver, CO, May 2010.

Grimbeek, Peter *et al.*, 'Use of data collapsing strategies to identify latent variables in questionnaire data: Strategic management of junior and middle school data on the CHP questionnaire' (Paper presented at the Proceedings of the 3rd Annual International Conference on Cognition, Language and Special Education, Griffith University Gold Coast, Queensland, 2005) <<http://www.grimbeek.com.au/Papers/CHP%20instrument.pdf>>

Johns, Rob, 'Likert Items and Scales' (Survey Question Bank: Methods Fact Sheet, 1 March 2010) <<http://www.surveynet.ac.uk/sqb/datacollection/likertfactsheet.pdf>>.

Johnson, Timothy P and Michael Fendrich, 'A validation of the Crowne-Marlowe Social Desirability Scale' (Paper Presented at the 57th Annual Meeting of the American Association for Public Opinion Research, St. Pete Beach, FL, 2002) <<http://www.srl.uic.edu/publist/Conference/crownemarlowe.pdf>>.

Kelk, Norm *et al.*, 'Courting the Blues: Attitudes towards depression in Australian law students and legal practitioners' (Report, Brain & Mind Research Institute, 2009).

Kirby, Michael, 'The Need for Clinical Experience in Australian Law Schools' (Paper presented at the International Association of Law Schools Conference, Canberra Australia, 26 May 2009)

<http://www.michaelkirby.com.au/images/stories/speeches/2000s/2009+/2357.International_Association_Of_Law_Schools_-_26_May_2009>.

MacPhail, Alison and Simon Verdun-Jones, 'Mental Illness and the Criminal Justice System (Symposium, Re-Inventing Criminal Justice: The Fifth National Symposium Montreal Quebec, January 2013).

Matsuo, Hisako and Kevin McIntyre, 'Ambivalent Prejudice toward Immigrants: The Role of Social Contact and Ethnic Origin' (Paper presented at the annual meeting of the American Sociological Association, Philadelphia PA, 2009)

<http://www.allacademic.com/meta/p20113_index.html>.

McCall, Chester H, 'An empirical examination of the Likert scale: Some assumptions, developments, and cautions' (Paper presented at the 80th Annual CERA Conference, South Lake Tahoe, CA, November 15-16, 2001)

<<http://faculty.pepperdine.edu/cmccall/CERAFinal.pdf>>.

President Clinton, *We must make it clear, once and for all: mental illness is no different from physical illness*, Remarks at the White House Conference on Mental Health, 1 Published Papers 896.

Slade, Tim *et al.*, 'The mental health of Australians 2: Report on the 2007 national survey of mental health and wellbeing' (Report, Department of Health and Ageing Australian Government, May 2009).

Swami, Viren, 'Mental Health Literacy of Depression: Gender Differences and Attitudinal Antecedents in a Representative British Sample' (2012) 7 *PLOS ONE*.

The Commonwealth of Australia, 'Australian – Educating Globally: Advice from the International Education Advisory Council' (Advice, International Advisory Council, February 2013) <<https://aei.gov.au/IEAC2/theCouncilsReport/Documents/Australia%20-%20Educating%20Globally%20FINAL%20REPORT.pdf>>.

The Mental Health Legal Centre Inc., '20/20 Hindsight: A History of the Mental Health Legal Centre Inc.' (Report, Mental health Legal Centre Inc., November 2006).

The Scottish Government, 'Well? What Do You Think? (2008): The Fourth National Scottish Survey of Public Attitudes to Mental Wellbeing and Mental Health Problems' (Report, The Scottish Government, 2008)

<<http://www.scotland.gov.uk/publications/2009/09/15120147/10>>.

D. Media and websites

'Women leading with the law', *Lawyers Weekly*, 10 March 2011

<<http://www.lawyersweekly.com.au/news/women-leading-with-the-law>>.

<http://www.communitylaw.org.au/clc_mentalhealth/cb_pages/images/20_20_Hingsight_Final.pdf>.

Bayer, Rich, Mental illness & violence: A flawed connection, *Cecil Daily*, April 26, 2013, <http://www.cecildaily.com/opinion/columns/article_875109aa-ae0e-11e2-b810-0019bb2963f4.html?TNNoMobile>

Harvard Law School <<http://www.law.harvard.edu/academics/clinical/pro-bono/index.html>>.

Legg, Michael and John Corker, 'Take care in pushing student pro bono', *The Australian* (online) 26 April 2013 <<http://www.theaustralian.com.au/business/legal-affairs/take-care-in-pushing-student-pro-bono/story-e6frg97x-1226629553945>>.

Metherell, Mark, 'Mental health failure tied to prejudice: McGorry' *The Age* (online), 23 June 2010 <<http://www.theage.com.au/national/mental-health-failure-tied-to-prejudice-mcgorry-20100622-yvuf.html>>.

TC Beirne School of Law, *Pro Bono Roster* (2010) The University of Queensland <<http://www.law.uq.edu.au/pro-bono-roster>>.

Trachtenberg, Ben, 'Rethinking Pro Bono By Ben Trachtenberg', *New York Times* (online), 13 May 2012 <<http://www.nytimes.com/2012/05/14/opinion/a-better-pro-bono-plan.html>>.

CONCLUSION

A most important lesson learnt by law students is that the law only works well when there is a level playing field - that justice will be done only when rules are applied evenly and decisions are made impartially. The lesson learned from legal practice, however, is that the legal system does not always provide a level playing field and that power and powerlessness have a major impact on when, and how, the law is applied. Michael Perlin first learned this lesson while working as a mental health law public defender in New Jersey during the 1970s. His early experiences laid the foundation for over thirty years of practice, teaching, thinking and writing in the area of law and mental illness. He became convinced that the legal system is inherently biased against mental illness and that it is impossible to understand truly the law's prejudiced treatment of people who experience mental illness - its doctrines, discourse, decisions and dissents - without first dealing with the reality of this proposition. It is Perlin's contention that the apparent contradictions, internal inconsistencies and cognitive dissonance of mental health law are incapable of understanding, without first appreciating fully, the power and pervasiveness of sanism.

The first intention of this thesis was to examine Perlin's claim that sanism permeates the political and legal systems. It would test the validity of Perlin's assertions that sanism riddles social policy, is written into law, and influences judicial decision-making.¹ Commencing this task required an examination of the varied perceptions of what stigma, sanism and prejudice are, and a discussion of the theories about why, and how stigma associated with mental illness continues to perpetuate. Despite the significant global attention directed toward reducing stigma, decades of anti-stigma measures have largely been unsuccessful in changing public attitudes. 'Abnormal' people who experience mental illness continue to evoke fear and fuel the desire for social distance within society's 'normal' group.

¹ Michael L Perlin and Deborah A Dorfman, 'Sanism, social science, and the development of mental disability law jurisprudence' (1993) 11 *Behavioral Sciences & the Law* 47.

The discussion in Chapter One explored the seemingly indifferent approach that public health policy-makers have taken toward creating a universally agreed, unique, coherent and ideologically appropriate mental health model. A review of Australia's mental health policies showed significant jurisdictional variances. While it was found that a number of jurisdictions favour the psychosocial model, some jurisdictions continue to support the pathologisation, categorisation and objectification characteristics of the biomedical model, while other jurisdictions are increasingly relying on incongruous paradigms such as the social disability model, which have been seconded from other areas of social disadvantage. The theoretical and definitional inconsistencies that exist between the different mental health policies within a jurisdiction were also identified, as was significant non-compliance with international human rights instruments.

Policy-makers appear to have become dependent on inspirational rhetoric in their attempt to achieve important social goals while generally ignoring the importance of developing clear, precise language and consistent mental health definitions. As a consequence, the mental health system is inculcated with problems of competing and conflicting paradigms, ideological differences, and language deficiencies that have failed to provide the law with clear and consistent messaging that offers real interpretive value. These policy deficits have left the Australian legal system standing atop a poorly defined and conceptually confused mental health law foundation that lacks the required clarity, precision and consistency needed by the law if it is to achieve predictable, fair, non-arbitrary outcomes for parties experiencing mental illness.

The law's interests in mental health have historically rested on the negative perception of mental health as a disease and an illness. Legal decision-makers are positioned to determine whether a legal party (1) has a mental illness, (2) has legal capacity now, or had it at the time of a specific instance of legal import, (3) needs to be compulsorily detained and/or treated, and (4) represents a risk. Arriving at the answers, decision-makers use biased reasoning, ignorant as they are to their own prejudices, and rely on medico/legal doctrines and legislation, that promote abnormality and difference, forced intervention and separation. The legal system has been, and continues to remain, disconnected from the aspirational, and to date, largely ineffectual goals of the public health mental health policies. But while

policy-makers have neglected to provide the legal system with clear and consistent definitional guides, the law has been just as lax in attempting to redress the doctrinal, conceptual and definitional problems, which leave it susceptible to claims of arbitrariness, and discrimination in its application.²

When a person medically labelled as ‘mentally ill’ comes into contact with the legal system, that system additionally labels them with a slew of negative characteristics that immediately disadvantages them in their legal matters. They are stereotyped as unpredictable, disorganised, incredulous, incapable, untruthful and dangerous.³

These harmful attributes grounded in myths, stereotypes, superstition and de-individualisations⁴ are what drive the law’s presumptary beliefs, which maintain the law’s injurious and irrational prejudice. Understandably, the legal system has not widely embraced Perlin’s notion of sanism, most probably because accepting sanism can be extremely confronting, personally and professionally for legal actors. Perlin does not have a light touch. Rather than suggesting that some legal actors may be prejudiced, Perlin emotes emphatically that sanism ‘infects the judiciary, the legislature, the bar and the legal academy’.⁵ He insists that because of sanism and pretextuality - the court’s legal artifices - the law proceeds on the edge of hidden prejudice in its dealings with people who experience mental illness: a prejudice that, Perlin argues, has led to the corruption of mental health law.⁶ He uses language such as ‘infects’ and ‘corrupts’ as weapons in his war against the mental health law injustices that he has witnessed.

The legal system has conceptually, long been satisfied with the biomedical model with its characterisation of mental health ‘patients’ as abnormal, different, disabled, dysfunctional and at risk of harming self or others. In particular, it is the ‘risk of harm to others’ factor that has occupied the minds of legislators and legal decision-makers to the extent that it is most usually the determinant factor. Acceptance of the biomedical approach has meant that psychiatry has been permitted to penetrate every area of law in which mental illness is a factor, and where a party’s credibility,

² Bruce J Winick, ‘Ambiguities in the legal meaning and significance of mental illness’ (1995) 1 *Psychology, Public Policy, and Law* 534.

³ Michael L Perlin, *The Hidden Prejudice: Mental Disability on Trial* (American Psychological Association 2000).

⁴ Michael L Perlin, ‘Half-Wracked Prejudice Leaped Forth’: Sanism, Pretextuality, and Why and How Mental Disability Law Developed as it Did’ (1999) 10 *Journal of Contemporary Legal Issues* 36, 5.

⁵ Perlin, above n 1, 48.

⁶ *Ibid* xviii.

culpability, competency, compensation, and custody are at legal issue.⁷ The law has become wholly reliant on the expertise of psychiatrists to understand, assess, and explain mental illness - its causation and cures - to legal decision-makers even though psychiatry itself is an unscientific discipline that is dependent on a system of unreliable categorisations. Psychiatric assessments are based on observations and psychiatric explanations, which consist of intuitive predictions comparable to educated guesses. Once a person has been diagnostically labelled as 'mentally ill', however, legal decision-makers view their predicted futures as suspect, in line with, or at times despite, the pronouncements of the psychiatric expert witness.

Chapter Three demonstrated that stigma is a multi-faceted, pervasive and harmful social construct involving attitudes, feelings and behaviours and existing within the context of social power in an environment of social inequality. The major stigma theory presented in this thesis is Erving Goffman's classic devaluation and dehumanisation theory, which activates when human differences are identified.⁸ These differences are then linked to undesirable characteristics that are exaggerated through the use of symbolic reductionist stereotypes and used to reify the social, cultural, medical, behavioural and political myths that are attached to mental illness.⁹ Stereotypes inform how the public thinks about mental illness, and how it treats people labelled 'mentally ill'. Labelling the person in this way marks them as inferior and dysfunctional, characteristics that are used to justify society's prejudicial and discriminatory responses to the person's exaggerated differences.

The worst form of discrimination is structural/institutional discrimination, because of the impact that basic institutions have on the daily lives of disadvantaged and vulnerable people. The institutional embeddedness of mental illness stigma reacts to the individual's psychiatric difference. The public's inherent desire to be separated from the abnormal 'Other' - labelled as ill, damaged and damaging, incapable, insensible and dangerous - is animated. The law's role in distancing the abnormal from the normal is regulating and managing the 'Other's' unacceptable behaviours and anomalous life experiences in ways that control and restrict autonomy and

⁷ Ralph Slovenko, *Psychiatry in law/law in psychiatry* (Taylor & Francis, 2009) xi.

⁸ Erving Goffman was a sociologist prominent for his analyses of human interaction. He relied less on formal scientific method than on observation to explain contemporary life.

⁹ Michael L Perlin, 'Unpacking the Myths: The Symbolism Mythology of Insanity Defense Jurisprudence (1990) 40 *Case Western Reserve Law Review* 599.

opportunities, keeping normal society safely distanced from unwarranted and dangerous interactions. Perlin argues that the law's response to this responsibility has been stigmatic. The legal system applies exactly the same harmful stereotypes, myths and prejudices that people who experience a mental illness encounter in their everyday lives.

This is not to suggest that the law has not been instrumental in trying to reduce the impact that stigma, prejudice and discrimination has on society. During the last fifty years, the world has experienced major social change driven by liberal social policies influenced by cultural interventions and regulated by anti-discrimination laws. Immutable qualities of gender, race, ethnicity, sexuality and youth have gained newly respected rights and protections, which are reflected world-wide in landmark legal cases such as *Roe v. Wade*¹⁰ and *Mabo*.¹¹ The ideology of political correctness has been incorporated into statute to regulate out of cultural convention those forms of expressions that exclude, marginalise, disrespect and insult certain social groups.

Language has intended and unintended meanings that can influence how people think and feel about particular subjects such as immigration issues. It is a communication medium through which messages that are vague, ambiguous and contradictory can be transmitted with unintended stigmatising meanings, which are often more insidious and socially destructive than messages that have intended negative meanings.¹² These messages are absorbed into common parlance from whence they perpetuate the socially constructed power dynamics between the rational and the irrational, the mentally healthy and the mentally unwell, and the normal and the inferior 'Other'. The greatest threat lies in the invisibility of the 'commonplace': the social acceptance of that which, if it was other than mental illness, would be socially unacceptable. Stigma is highly resistant to change but when it is associated with mental illness, it is uniquely acceptable to courts blind to this 'hidden prejudice'.

¹⁰ *Roe v. Wade*, 410 U.S. 113 (1973)

¹¹ *Mabo v Queensland* (No. 1) (1988) 166 CLR 186, *Mabo v Queensland* (No 2) ('Mabo case') [1992] HCA 23

¹² Mona Shattell, 'Stigmatizing Language with Unintended Meanings: "Persons with Mental Illness" or "Mentally Ill Persons"?' (2009) 30 *Issues in Mental Health Nursing* 199.

Distinct from matters of racial or gender offensive language, courts have generally shown a willingness to validate offensive, disrespectful or deprecating language when it is connected to mental illness based on the cultural assimilation of the offensive, insulting, disrespectful words and terms into everyday language, and the frequency of their use. For example, Roget's online Thesaurus offers 22 synonyms for the term 'mentally ill' of which all of the suggested words and phrases including 'nuts', 'loony' and 'off one's rocker' are inappropriate, disparaging or offensive.¹³ On the other hand, when the word 'disabled' is keyed in, it will produce 24, appropriate and inoffensive examples such as 'stalled', 'incapacitated' and 'out-of-commission'.

The purpose of Chapter Six was to test whether, as Perlin contends, sanist law and sanist judges treat people who experience mental illness unfairly. This was done by critically reviewing the non-neutral domain of parenting decision-making, and undertaking a specific case study of conflicted parenting family law cases in which one parent had a mental illness. The social science empirical parenting literature tends to represent parents with a mental illness as permanently flawed and incapable of good parenting.¹⁴ Having a 'mentally ill' parent is widely considered detrimental to the child who is, or potentially will be, adversely affected by their parent's neglect, physical harm, psychological upset, or as an indirect consequence of the social and environment factors associated with mental illness. The negative attributes of bad parenting - neglect, irresponsibility, disorganisation, disinterest, and abusive/violent behaviour - mirror the stereotypically accepted abnormal manifestations of mental illness. It is this social perception of the 'mentally ill' parent as permanently damaged, and damaging, which helps to negatively shape the major life decisions that are made about, and for the parent and child, by social workers, police officers, welfare workers and judicial officers.

The legal system has absorbed the biomedical disease model, which implicitly presumes that people who have a mental illness are unfit. Consequently, the legal system generally views parents who have experience of a mental illness as unfit parents. This is confirmed by an application of the social scientist's adversity

¹³ Roget's Thesaurus, (Dictionary.com, 2013) <http://thesaurus.com/Roget-alpha-index.html%E2%80%8E>

¹⁴ Barry J Ackerson, 'Parents with serious and persistent mental illness: Issues in assessment and services' (2003) 48 *Social Work* 187.

paradigm which labels the parent as detrimental to the well-being and healthy development of their child. It is this predominately pathologically focused social scientific research into parenting capabilities that has instilled the stereotypical image of the unfit parent into the social mind. The parent is deemed less predictable, less emotionally available, less reciprocal, less involved, less affectionate, less responsive, less encouraging and less positive than what is socially expected of the idealised ‘good’ parent. But most importantly, they are also categorised as dangerous, or potentially so; a risk that the law finds ‘unacceptable’.

A review of the *Family Law Act* 1975 revealed that the ‘unfit parent’ stereotype has been anchored into the legislation within provisions that lack the necessary precision and definitions discussed in Chapter One. The statute lays down assessment measures. For example, it must be shown that the parent has a ‘meaningful relationship’ with the child, however, the Act does not define the term nor does it provide guidance for judges as to how it should be interpreted. Judges hold the same negative attitudes and cultural presumptions, rely on the same myths and stereotypes, and demonstrate the same biased behaviours borne out of fear, anxiety, and paternalistic beneficence as does the rest of society. They use heuristic reasoning to arrive at quick, intuitive assessments regarding character and future prospects, and just as people have a tendency to interpret information in a way that confirms their pre-existing beliefs and attitudes about themselves and their social world, legal decision-makers do the same.

This became apparent in the review of Australian family law conflicted parenting order cases. The review found that if courts were of the mind that a parent had a mental illness, this fact significantly increased their risk of receiving a harsher and more restrictive parenting outcome. The case studies showed that judges followed the social sciences’ adversity approach. They used unfavourable characteristics to prejudge with a level of certainty the potential detriment to the child’s well-being that would be caused by the parent’s poor parenting. Judges were much more likely to associate cues of violence, neglect, unpredictability, instability, poverty, and inadequate parenting skills with the parent who had a mental illness than with a parent who did not. They also tended to interpret the parent’s mental illness as representing an ‘unacceptable risk’ to the child. Although the study was conducted

in a small, well defined area of judicial determination, the research provided support for Perlin's claim that the legal system is sanist.

Having established this level of validity to Perlin's claim that the legal system is sanist, the thesis turned its attention to how it might counteract the prejudices of the legal system. The first six chapters provided a great deal of academic insight into what stigma, sanism and prejudice are, and how the legal system discriminates against parties that experience a mental illness. Chapter Seven offered an option for positive change by presenting a clinical legal model for academic evaluation. Since 2003, the Mental Health Tribunal Representation Scheme (MHTRS) has provided mental health skills and awareness training for University of Tasmania law students who then represent clients appearing before the Tasmanian Mental Health Tribunal (MHT) on civil commitment and compulsory treatment orders.

The MHTRS is built on the therapeutic jurisprudence model that Perlin believes to be the only theoretical solution 'that has the potential power to "strip the sanist facade"'.¹⁵ He considers therapeutic jurisprudence to have far reaching potential in enabling society to come to grips with the pernicious power of sanism and pretextuality. It provides opportunities to make coherent the incoherent and expose the hidden.¹⁶ Attitudinal change literature has shown that the best outcomes have been achieved through short term, structured programs, which combine education and contact stratagems targeting young people. It was surmised that due to the length of time that the MHTRS had been operating (11 years), and the large number of law students that had participated in its training and delivery of representation services, the MHTRS would provide valuable data for the empirical research reported in Chapter Eight.

Perlin argues that sanist attitudes are prevalent in the teaching of law students, both overtly and covertly, through sanist thoughts and sanist myths but that the extent that it affects law teachers and law students is not known.¹⁷ The intent of Chapter Eight was, to some extent, to make the unknown known. A survey of 204 first and fifth year law students was conducted with the purpose of empirically testing

¹⁵ Michael L Perlin, "'His Brain Has Been Mismatched With Great Skill': How Will Jurors Respond To Neuroimaging Testimony In Insanity Defense Cases?" (2009) 42 *Akron Law Review* 885.

¹⁶ Perlin, above n 3, 303.

¹⁷ Michael L Perlin, "'You Have Discussed Lepers and Crooks': Sanism In Clinical Teaching" (2003) 9 *Clinical Law Review* 683.

Perlin's claims to determine whether the reported attitudes and beliefs of the respondents were sanist. It also assessed whether the responses of the final year students were more, or less sanist, than the first year students, and whether a student's participation in the MHTRS could be shown to have a positive influence on improving attitudes.

Although the study had a number of weaknesses, which were discussed in Chapter Eight, it did return some important findings. A major weakness was the high level of 'No opinion' responses. The opinionated responses, however, indicated that law students are sanist. They strongly reported benevolent and authoritarian responses. Females were more benevolent and males were more authoritarian. There was a slight, overall trend, showing that the final years had developed more authoritarian attitudes and 1st year students were more stereotyping in their responses. Both groups had labelled their future legal clients as 'difficult'. Surprisingly, there was limited support for 'free' legal Mental Health Tribunal representation except from the small group who identified as having personally experienced a mental illness. Unfortunately, there was insufficient data to reach a finding that participation in a therapeutic jurisprudence clinical program similar to the MHTRS had a positive influence on the attitudes of students. The smallness of the sample meant that the results were unreliable.

Importantly, the study identified the popular use among law students of offensive and disparaging language, which reinforces Perlin's concept of sanism as socially acceptable. Prejudicial beliefs are wired into language and using stereotyping terms succeeds in evoking negative associations in listeners even when the speaker does not consciously endorse the stereotypes. When in December 2012, the American House of Representatives, 'at the urging of psychologists, who argued the definition is outdated and offensive'¹⁸ voted 391-1 to ban the word 'lunatic' from all federal legislation because 'antiquated terms as "lunatic" perpetuates the social stigma surrounding mental illness', the lone dissenter referred to his fellow Representatives as 'lunatics'.¹⁹

¹⁸Timothy R Homan, Congress Ousts Lunatics. Idiots Remain, *Bloomberg Business Week*, 13 December, 2012, <http://www.businessweek.com/articles/2012-12-13/congress-ousts-lunatics-dot-idiots-remain>

¹⁹ Emma O'Connor, Congress Overwhelmingly Votes to Ban the Word 'Lunatic', *Time*, December 6, 2012, <http://newsfeed.time.com/2012/12/06/congress-overwhelmingly-votes-to-ban-the-word-lunatic/>

While government actions such as this represent a positive sally for attitudinal change, it is important to note that sanism does not flourish because the occasional offensive word is incorporated within statutes, of which the vast majority of society's members will be unaware. A more productive question might be how many of the 391 politicians who voted to remove the legislative term returned home to their families to call their wife, a 'mad shopping fiend'; their husband a 'crazy bike rider'; their son a 'psycho on the skateboard track'; and their moody teenage daughter, 'schizophrenic, with a split personality'.

Society does not condone prejudice, or its discriminations being perpetrated against people with mental illness, it commonly just fails in its ability to recognise them when they occur. It expects that people who experience mental illness will be controlled and treated for their own good, and for the good of the rest of society's members, because they are incompetent, incapable, unpredictable, erratic, irresponsible, vulnerable, and dangerous, or potentially so. This layer of negative stereotyping supports an additional layer of stereotypical assumptions such as they are poor employees, poor tenants, bad financial and health risks, and they are bad parents, all of which reduce lifestyle opportunities, and impact on the person's mental health.

Society also holds the belief that if it were not for the mental illness, the person would be grateful for the imposition of laws and judicial decision-making that ensure that they are protected, controlled and treated. This collective belief is justification for the loss of autonomy, loss of rights, deprivations of liberty, loss of bodily integrity and forced treatments imposed on people with a mental illness. There are no similar, acceptable, justifications in issues of race, gender or homosexuality, and no-one believes that a suffragette would have been grateful for being imprisoned and gastric fed; or an African American would have been grateful for being enslaved; or a cancer patient who is refusing treatment will be grateful for being locked up until they agree, or are compelled, to undergo chemotherapy.

If society generally, and the legal system specifically, are to become less sanist, they must first recognise and acknowledge the prejudices and discriminations experienced by people who experience mental illness. It is essential that judges and lawyers, legislators and educators become aware of their own assumptions about

human behaviour, values, biases, preconceived notions, personal limitations, and that they try to actively understand the different world view of a person experiencing a mental illness, without negative judgment. This can be achieved through the establishment of compulsory, ongoing education and training schemes that require legal professionals to annually attain a certain number of professional development credits in mental health. Better informed and more aware lawyers will proceed to becoming better informed, and more aware, policy makers, judges and legislators.

A crucial first step is recognising that sanist attitudes and behaviours are present on law school campuses. Law schools have a duty to support and implement policy, practice and curriculum changes that challenge the negative attitudes of students and staff, and help to develop a culturally affirmative orientation for students. While more research is needed to clarify and extend the findings regarding the influence of the Mental Health Tribunal Representation Scheme on attitudinal change, this thesis did provide evidence for the value of well structured and well supervised programs of experiential learning; clinical legal programs that offer students therapeutic jurisprudence based mental health education, and the opportunity for students to have personal contact with mental health consumers (guest speakers) and professional contact with clients experiencing a mental illness. Further research is also needed to assess whether these types of schemes can inculcate a pro bono ethos in law students prior to practice.

This thesis has demonstrated the importance of settling on universal concepts, agreed definitions, consistent messaging and common language that transverses public policy and law. It is hoped that the thesis has provided a necessary impetus for future research and policy development to achieve this outcome. Most commentators define the negative stereotyping, labelling, prejudice and discrimination associated with mental illness in a broad, umbrella sense as ‘public stigma’. Perlin calls it ‘sanism’; an ‘ism’ no different to racism, sexism, and every other ‘ism’ society no longer tolerates. A first step in achieving a universal message is gaining global agreement that the term ‘sanism’ is used broadly to describe the stereotyping, stigma, prejudice and discrimination associated with mental illness.

Both the doctrinal and empirical research undertaken in this thesis provides clear and coherent evidence that the legal system is prejudiced against people who experience mental illness, and as Perlin argues, it is hidden in its social acceptability. Public health antistigma campaigns need to move beyond the 'health facts' approach because sanism is embedded in language. Negative social attitudes infect language and negative language creates negative attitudes. Public health policy-makers, mental health antistigma literacy programs, social scientists, legislators, courts, lawyers, academic commentators and legal educators need give attention to making sanism visible, and ensuring that it is no longer acceptable. Until this happens, people who experience mental illness will continue to be disadvantaged by a legal system blind to its own prejudices and discriminations.

BIBLIOGRAPHY

A. Articles

Ackerson, Barry J, 'Parents with serious and persistent mental illness: Issues in assessment and services' (2003) 48 *Social work* 187.

Perlin, Michael L and Deborah A Dorfman, 'Sanism, social science, and the development of mental disability law jurisprudence' (1993) 11 *Behavioral Sciences & the Law* 47.

Perlin, Michael L, "'You Have Discussed Lepers and Crooks': Sanism In Clinical Teaching' (2003) 9 *Clinical Law Review* 683.

Perlin, Michael L, "'His Brain Has Been Mismanaged With Great Skill": How Will Jurors Respond To Neuroimaging Testimony In Insanity Defense Cases?' (2009) 42 *Akron Law Review* 885.

Perlin, Michael L, 'Half-Wracked Prejudice Leaped Forth": Sanism, Pretextuality, and Why and How Mental Disability Law Developed as it Did' (1999) 10 *Journal of Contemporary Legal Issues* 36.

Perlin, Michael L, 'Unpacking the Myths: The Symbolism Mythology of Insanity Defense Jurisprudence (1990) 40 *Case Western Reserve Law Review* 599.

Shattell, Mona, 'Stigmatizing Language with Unintended Meanings: "Persons with Mental Illness" or "Mentally Ill Persons"?' (2009) 30 *Issues in Mental Health Nursing* 199.

Winick, Bruce J, 'Ambiguities in the legal meaning and significance of mental illness' (1995) 1 *Psychology, Public Policy, and Law* 534.

B. Books

Perlin, Michael L, *The Hidden Prejudice: Mental Disability on Trial* (American Psychological Association 2000).

Roget's Thesaurus, (Dictionary.com, 2013) <http://thesaurus.com/Roget-alpha-index.html%E2%80%8E>

Slovenko, Ralph, *Psychiatry in law/law in psychiatry*. Taylor & Francis, (2009).

C. Cases

Mabo v Queensland (No. 1) (1988) 166 CLR 186,

Mabo v Queensland (No 2) *Mabo and Others v Queensland* (No. 2) [1992] HCA 23.

Roe v. Wade, 410 U.S. 113 (1973).

D. Media and websites

Emma O'Connor, Congress Overwhelmingly Votes to Ban the Word 'Lunatic', *Time*, December 6, 2012, <http://newsfeed.time.com/2012/12/06/congress-overwhelmingly-votes-to-ban-the-word-lunatic/>

Timothy R Homan, Congress Ousts Lunatics. Idiots Remain, *Bloomberg Business Week*, 13 December, 2012, <http://www.businessweek.com/articles/2012-12-13/congress-ousts-lunatics-dot-idiots-remain>

APPENDIX 1

Please answer the question below by circling the number to the right that best describes how you feel about the statement being made. Please rate all the statements.

Question 4 I think that GENERALLY the mentally ill -	Scale of Importance				
	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree
should be treated differently to other people	1	2	3	4	5
can't look after themselves properly	1	2	3	4	5
behave badly in public	1	2	3	4	5
are treated equally and fairly by the law	1	2	3	4	5
are dangerous	1	2	3	4	5
need doctors to make decisions for them	1	2	3	4	5
are stigmatized and discriminated against	1	2	3	4	5
should be in psych hospitals and asylums	1	2	3	4	5
don't know right from wrong	1	2	3	4	5
can't make rational decisions	1	2	3	4	5
want to live together in hospitals instead of living in the community	1	2	3	4	5
are erratic and emotionally unstable	1	2	3	4	5
have rights that must be protected	1	2	3	4	5
need to be controlled by laws	1	2	3	4	5
are treated badly by the media	1	2	3	4	5
need to be protected	1	2	3	4	5
commit crimes	1	2	3	4	5
need their own special laws	1	2	3	4	5
are morally weak and deviant	1	2	3	4	5
lack intelligence and are uneducated	1	2	3	4	5
scare me	1	2	3	4	5
Are unpredictable	1	2	3	4	5

Other.....

.....

.....

.....

APPENDIX 2

Please answer the question below by circling the number to the right that best describes how you feel about the statement being made. Please rate all the statements.

Question 6 I think mentally ill legal clients GENERALLY	Scale of Importance				
	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree
would be difficult clients for lawyers to represent	1	2	3	4	5
would be unable to properly instruct their lawyer	1	2	3	4	5
could help in developing their case strategy	1	2	3	4	5
should do what their lawyers tells them	1	2	3	4	5
would find the law too complicated to understand	1	2	3	4	5
always have their rights respected	1	2	3	4	5
would need their behaviour controlled by their lawyer	1	2	3	4	5
want what is often not a medically good option for them	1	2	3	4	5
should be able to instruct their lawyers OK	1	2	3	4	5
know that their lawyer only acts in their best interests	1	2	3	4	5
lack the ability to know what is their own best interests	1	2	3	4	5
have to be treated differently to other types of legal clients	1	2	3	4	5
trust their lawyers	1	2	3	4	5
just want someone to help them	1	2	3	4	5
are dangerous and put their lawyer's safety at risk	1	2	3	4	5
are labeled and judged unfairly	1	2	3	4	5
should be able to get a lawyer for free	1	2	3	4	5
don't really know what is going on anyway	1	2	3	4	5
don't listen well	1	2	3	4	5

Other.....

APPENDIX 3

(Please circle your most appropriate response to each question)

- 1. When did you last see a film or television show in which a ‘mad psycho killer’ was portrayed?**

This week Past month Past Year Never Don’t remember

Briefly describe the character.

.....

.....

.....

- 2. Have you read/seen a news article when you thought that the person who committed such a terrible crime must be insane?**

Often Occasionally Rarely Never Don’t Remember

- 3. Do you use terms such as looney, loopy, basket case, nut, nutter, nutso, nutjob, crazy, psycho, wacko, potty, screwy, bonkers, cuckoo, batty, bananas, etc?**

Often Occasionally Rarely Never Don’t remember

- 4. What 5 words best describe how you feel about the mentally ill?**

1.

2.

3.

4.

5.

5. When did you last see a mentally ill person in the street?

This week Past month Past Year Never Don't remember

Briefly describe how you knew they were mentally ill.

.....

.....

.....

.....

6. I would never marry a person who had a mental illness.

Strongly agree Agree No opinion Disagree Strongly Disagree

7. Schizophrenia is an illness like any other illness such as asthma, diabetes etc.

Strongly agree Agree No opinion Disagree Strongly Disagree

8. The mentally ill should be forced to take medication if they refuse.

Strongly agree Agree No opinion Disagree Strongly Disagree

APPENDIX 4

Mental Health Tribunal Representation Scheme Skills and Awareness Certificate Training Three One Hour Lecture Series Objectives

Certificate in Skills and Awareness in Mental Health

The certificate is awarded to all students who attend all three lectures. The five goals of awarding the certificate are;

- to increase awareness of mental illness and the issues and barriers faced by people with a mental illness
- to provide some skills for future professionals to better work with clients who experience a mental illness
- to offer greater opportunity for law students to gain employment.
- to offer potential employers with an additional gauge to assess employment applicants
- to deliver the initial training necessary for persons wanting to proceed on to further training as a representative of the scheme

Lecture 1 – Social Perspective: Barriers for People Living with Mental Illness

Objective 1

Trainees have a greater awareness of stigma and the prejudice and discrimination experienced by people with mental health issues.

Key Points

- Explore stigma and discrimination
- Examine the roles that myth and media play in perpetuating stigma, prejudice and discrimination.

- Show how individuals and social institutions including the health system (doctors, nurses and allied health professionals) and the legal system (judges, lawyers, probation officers etc) stigmatise and discriminate against people who experience mental illness.

Objective 2

Trainees are aware that in order to provide the best possible future services to their clients experiencing a mental illness, they must reflect on their own subjective biases, and be flexible enough to overcome them.

Key Points

- Provide an analysis of the ‘normal’ expectations that professionals have of clients, and client/professional relationships, and show why some clients will never fit this standard expectations model.
- Show that in the provision of a non-discriminatory best service, the professional must adjust their practices to better meet the needs of their client.
- Provide additional skills required to ensure that future clients receive an optimal service.

Lecture 2 – Clinical Perspective: Mental Illness, Symptoms and Signs

Objective 1

Trainees have the ability to recognise, and understand, the associated symptoms and behavioural signs of the different disorders. The lecture is delivered by a mental health clinician using a program that is a condensed version of the Mental Health First Aid training developed by Kitchener & Jorm in 2002. (Red Cross Tasmania specifically designed the MHTRS program in early 2003)

Key Points

- Increase knowledge of the major mental health disorders and their symptoms and signs
- Provide an understanding of how mental health disorders can affect thought processes, and trigger behaviours that do not fit social norms

Lecture 3 – Skills in Working with Clients with a Mental Illness

Objective 1

Positive outcomes for clients experiencing a mental illness will be increased

Key Points

- Improve the communication skills of the future professionals working with clients who are experiencing mental illness.

Objective 2

Trainees have the practical skills to minimise personal risks

- Ensure trainees are able to implement appropriate occupational health and safety strategies

Objective 3

Trainees are able to connect the skills theory with practical implementation through listening to the experiences of guest speakers. Guest speakers are chosen from current and former magistrates, Official visitors, practising lawyers, social workers and former MHTRS representatives, all of whom give practical insight into working with mental health clients, both in legal and non legal professional capacities, and the ways that can improve the trainees' future service delivery

Key Points

- Ensure that trainees understand the practicalities and difficulties of working with clients experiencing a mental illness
- Trainees can connect theory and implementation of the different learned skills
- Trainees can apply the newly learned skills so as to provide better outcomes for both the client, and the lawyer/professional themselves

Objective 4

Trainees have contact with mental health consumers. Consumer guest speakers are lawyers and magistrates who have personally experienced mental illness. They provide trainees with an understanding of the need to protect their own mental health and the mental health of their colleagues. They identify the barriers that they have faced in their professional careers and the barriers faced by their clients.

- Ensure trainees are aware of the mental health issues that face the legal profession.
- Ensure that trainees are aware of the strategies to protect their mental health.
- Ensure that trainees are aware of the stigma associated with mental illness in the legal profession and the need combat the discrimination that it fuels.

APPENDIX 5

**Mental Health Tribunal Representation Scheme
Representation Training
One Hour Lecture
plus
Four Hour Intensive Tutorial
Objectives**

Lecture 4 - Appearing before the Mental Health Tribunal

This is a 1 hour lecture delivered by the President of the Tasmanian Mental Health Tribunal (MHT) on the role and function of the Tribunal.

Objective 1

Representatives will be familiar with the *Mental Health Act 2013* and the required provisions for review of involuntary orders undertaken by the MHT

Key Points

- An analysis and history of the sections of the *Mental Health Act 2013* relevant to the review of involuntary orders
- An understanding of the Administrative Court processes relating to the MHT

Intensive Tutorial

The objectives of the four hour intensive training program are that representatives will have;

- a good understanding of the Mental Health Tribunal Representation Scheme (MHTRS) model
- a good understanding of Therapeutic Jurisprudence
- a good understanding of the relevant law
- a good understanding of the legal functions, processes and practices of the MHT
- a good understanding of natural justice

- a good understanding of ethics and professionalism
- a good understanding of the rights of people who experience mental illness
- skills in communicating with clients who have a mental illness
- knowledge and skills to ensure competent representation
- occupational health and safety skills
- good interview skills
- the ability to ensure that relevant information provided by the client during the interview is conveyed to the MHT
- the skills to provide a closing statement with direct reference to the legislative provision under review

The objectives are achieved through a combination of training methods:

- lectures
- group work
- interactive exercises
- role plays/interviewing exercises

The intensive tutorial is divided into the 6 sections outlined below.

1. Initial Session

- Welcome
- Overview of the scheme
- Background of the scheme
- How volunteers work within the scheme

2. The Model: Therapeutic Jurisprudence – The Representative

- Theory of Therapeutic Jurisprudence and its benefits
- The role of the representative in a Therapeutic Jurisprudential framework
- Lawyer or advocate?
- Pro Bono
- Principles of advocacy
- Who is the client when families are involved?
- Confidentiality
- Professional conduct
- Professional boundaries and conflict of interest

- Ethical dilemmas
- Debriefing
- The MHT Precepts and Environment
- Participants
- Non adversarial
- Informality
- Time management
- Rules of evidence
- Substitute decision-making and the issue of blame

3. The Law

- International Law and Human Rights
- The *Mental Health Act* 2013 (TAS)
- The right to representation
- The doctor's report
- Initial order
- Continuing care order and the necessary elements
- Community treatment order and the necessary elements
- Authority for temporary admission order and the necessary elements

4. Mock Hearing

5. The Client

- Client allocation and the procedural steps of a representation
- Occupational health and safety issues
- Communicating with the client
- Using the doctor's report and client information to develop the case
- Empowering the client
- The importance of reporting

6. Role Plays and Practice Interviewing

APPENDIX 6

Mental Health Tribunal Representation Scheme

Therapeutic Jurisprudence Model

The Mental Health Tribunal Representation Scheme draws upon the therapeutic jurisprudential theory for its underpinning philosophies. It:

- encourages healing
- recognises the role that law has to play as a therapeutic agent
- is less confrontational
- is problem solving
- examines underlying social issues and the impact of law on society
- promotes a mixture of justice and psychology
- focuses on the mental well being of all participants
- focuses on the reduction of recidivism
- focuses on reaching desired outcomes for all participants
- resists a strict application of rules and laws
- promotes individualism
- focuses on what is right with a person rather than what is wrong
- searches for creative alternatives
- borrows tools used by other disciplines such as the ‘personal contract’ and the ‘voiced commitment’
- uses a cooperative approach rather than an adversarial approach
- promotes responsibility.

The Mental Health Tribunal Representation Scheme Therapeutic Jurisprudential Model;

- competently represents the client’s rights and obligations
- is non-adversarial
- tries not to harm the client’s existing relationships
- works co-operatively with the Mental Health Tribunal
- empowers clients by;
 - having a trained person ‘on their side’
 - being informed
 - feeling supported
 - being listened to